A MODEL FOR TRAINING DEACONS TO PROVIDE GRIEF CARE IN THE LOCAL CONGREGATION

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TABLE OF CONTENTS

TABLE OF CONTENTS.....i

ABSTRACT iii

ACKNOWLEDGEMENTS.....IV

DEDICATION

LIST OF TABLES.....VI

CHAPTER ONE THE CRISIS OF LOSS 1

The Good 'ol Days 1
From Riches to Rags 4
Groanings too Deep For Words 7
There Is A Balm 13

CHAPTER TWO INTRODUCTION TO THE MODEL 16

Understanding Grief 18
The Need For Grief Care 22
Tasks of Mourning 23
The Grief Process 29
What Is Grief Counseling? 34

CHAPTER THREE BIBLICAL AND THEOLOGICAL FOUNDATION 38

CHAPTER FOUR THE PROCESS 45

Covenant 45
Preparation 47
The Consultants 48
The Planning 48
The Support Team 54
The Format 56

CHAPTER FIVE THE FINDINGS 57

Attendance Patterns 57
Training Effectiveness Evaluations 61
Impact on Knowledge, Values, and Strategy 63
Conclusion 71

CHAPTER SIX REFLECTION, SUMMARY, AND CONCLUSION 72

Strengths 72
Weaknesses 80
Recommendations 82
Personal Growth 84

APPENDIXES

1. Training Manual 86
   including Funeral Procedure &
   Funeral Service Format)
2. Pre-Test Questionnaire 135
3. Post-Test Questionnaire 141
4. Grief Training Evalutive form.....146
5. Table 4 148
6. Table 5 149
7. Table 6 150
8. Table 7 154

ANNOTATED BIBLIOGRAPHY 159

GENERAL BIBLIOGRAPHY 169

ABSTRACT

A MODEL FOR TRAINING DEACONS TO PROVIDE GRIEF CARE IN THE LOCAL CONGREGATION

BY

Leslie David Braxton

UNITED THEOLOGICAL SEMINARY, 1996

MENTOR

J.T. ROBERSON, JR.

This project was designed to train deacons for grief care ministry in the First Shiloh Baptist Church of Buffalo, New York. Six training sessions were developed and implemented to provide deacons with an adequate understanding of the grief process, the tasks of mourning, and strategies for intervention. The learning experiences were framed by scripture, theology, grief theory and established principles of grief counseling. Results of the model were evaluated by both quantitative and qualitative analysis instruments, and show that the participants grew in their understandings of grief, their sensitivity to certain social issues related to death and their strategies for intervention.

ACKNOWLEDGEMENTS

I thank and praise Almighty God for giving me the strength and the ability to complete this model-in-ministry project and for encouraging my soul continually along the way.

I am eternally grateful to my beloved wife, Shelia, who held me up in prayer, and whose quiet, steady, and loving support continues to be the wind beneath the wings of my ministry, and the wings of our family and our home. And God be praised for my darling children, Karissa and Samuel, who have had to go to bed too many nights without their daddy being home yet for the sake of the completion of this project.

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their knowledge, guidance, and input this project could never have taken shape or form.

I thank all of the precious men and women of the First Shiloh Baptist Church Deacon and Deaconess Boards and all other participants who partnered with me in this model-in-ministry project. Their investment in me prepares for my greater investment in them.

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Finally, I am deeply appreciative to my secretary, Karen Bell, whose time I monopolized, whose nerves I wore out, and whose patience I tried. But without whom this document could never have taken form.

The Lord be praised, for the great things He has done!

THIS PROJECT
IS
IN MEMORY OF

NATHANIEL & NEALER PATTERSON

November 10, 1914 - November 22, 1978
July 3, 1922 - November 2, 1992
My Grandparents: "Bigdaddy & Bigmommy,"

"We have lost you awhile, but have loved you since;
Your memory remains until eternity's morning breaks."

and

IN MEMORY OF

REV. ROBERT H. DAVIS
July 18, 1922 - April 10, 1980
My Pastor,

"You were a patient hand during a
restless time in my life."

and

"Little"
NASERIA NADINE GARCIA STUBBS
February 2, 1989 - November 19, 1992
My Niece,

"You left too soon, but you gave so much so quickly"

LIST OF TABLES

TABLE **PAGE**

1. GENDER BREAKDOWN OF PARTICIPANTS IN TRAINING SESSION 58

2. TRAINING SESSION ATTENDANCE BREAKDOWN.....59

3. FREQUENCY OF TRAINING SESSION ATTENDANCE 60

4. DIFFERENCE BETWEEN PRE AND POST TOTAL SCORES .....65 & 148

5. COMPARISON OF PRE NOT IDEAL / POST IDEAL TO PRE IDEAL / POST NOT IDEAL.....67 & 149

6. KNOWLEDGE SUBTEST 150

7. VALUE SUBTEST 154

8. PARTICIPANTS RATING OF THE EFFECTIVENESS OF THE OVERALL TRAINING EXPERIENCE 62

9. COORDINATION OF TRAINING / QUALITIY OF TRAINING MANUAL....62

10. PARTICIPANTS RATING OF THE EFFECTIVENESS OF THE INDIVIDUAL SESSIONS.....62

CHAPTER ONE

THE CRISIS OF LOSS

By the Rivers of Babylon, there we sat down,
yea we wept, when we remembered Zion.

Psalm 37: 1

THE GOOD 'OL DAYS

Buffalo, New York is recognized as the "Queen City" of New York State. Located on the southeastern shores of Lake Erie, the city's original name was "Bfleu;" a French word meaning "city by the lake." However, many of the 19th century European immigrants who settled here had great difficulty with the correct pronunciation of the name, Bfleu (pronounced. Bfloo), and referred to their new home instead as "Buffalo." Eventually, the city officially changed its name to Buffalo to accommodate the speech proclivities of its majority residents.[1]

By the 1880's, Buffalo's commerce thrived as the Erie Canal provided the city with more millionaires per capita than anywhere else in the country.[2] Small businesses also

[1]Mark Goldman, City on the Lake: The Challenge of Change in Buffalo, NY. (Buffalo: Prometheus Books, 1990) 3.

[2]Curtis Haynes, Jr., "Buffalo's Story: African-Americans deal with decline in the former steel city," Dollar and Sense, January/February 1995, 16.

thrived, built around the commerce and shipping industries. Flower adorned parkways filled with charming horse drawn carriages and lined with manicured estates were the pride of this thriving city. Yet, new modes of transportation and communication soon rendered the shipping industry and the canal obsolete.

The city took a turn for the worse until a reprieve in the early decade of the 20th century when Buffalo flourished again, becoming the epitome of the industrial city. The new competitive "mass production" methods of industry caught hold. Working class families prospered, and blue collar industry became a path out of poverty for the poor and uneducated.[3]

African-Americans were among the many ethnic groups who migrated to the city of Buffalo in the early decades of the twentieth century with the hope of travelling the blue-collar pathway to a better life. Sparked by the first World War, African-Americans for the first time migrated to Buffalo in significant numbers. Prior to the start of World War I, only a few hundred African-Americans resided in Buffalo, many of whom were descendants of the Blacks who first settled in the area in the middle of the nineteenth century in connection with the underground railroad. By the mid-1920's, the African-American population had multiplied to over 7,000 and rapidly growing, settling into what was

[3]Goldman, 72.

then called the City Central district.[4]

For nearly five decades, a constant stream of African-American opportunity seekers flowed Northward into Buffalo from southern states. To the good fortune of most, African-Americans experienced a Buffalo that offered them gainful opportunities for work. African-American men and women found strenuous but stable and good paying jobs in Buffalo's plants and factories. Additionally, African-American women found opportunities as school teachers and as domestics in the homes of affluent white Buffalonians. Together, African-American men and women in Buffalo were able to make what was considered an unusually comfortable life for Blacks during this period. They bought their own homes, educated their children, built, owned and operated businesses, churches, fraternal and community organizations.

In 1916, against the backdrop of World War I and subsequently, the first great Northern migration of African-Americans, the First Shiloh Baptist Church (called "Shiloh" at the time) was established. Fed by the tremendous and perpetual stream of Black newcomers to the city, the First Shiloh congregation quickly and steadily grew. By 1925, First Shiloh's 2,000 plus membership represented nearly a third of the entire Black population in the city.[5]

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[4]Haynes, 6.

[5]David Merriweather, "A Look Back," Buffalo Criterion, December 9, 1996, 7.

By the late 1940's, First Shiloh had become the largest African-American congregation in the state of New York outside of New York City. The active membership roll climbed to its Zenith at just under three thousand. First Shiloh had become known as the "great colored church upstate". This extraordinary era of growth and stability for both the congregation and the city alike was personified by the remarkable forty-four year tenure of 'Shiloh's nationally renown pastor, the late Reverend Elijah J. Echols, Sr. (1918-1962). Buffalo and First Shiloh were in their heyday. Jobs were so plentiful in Buffalo during this period that there was a popular saying that "a man could quit his job in the morning and have two better jobs by noonday."

This wave of prosperity lasted almost until the final quarter of this century. Then the bottom dropped out.

FROM RICHES TO RAGS

What happened? In a word, Post-industrialism. Curtis Haynes, professor of economics at Buffalo State College, provides this explanation of the decline of Buffalo,

> The industrial sectors of the United States faced the challenges of a new, global form of competition, which emphasized speed, flexibility, and quality. The mass production model was suddenly outmoded. In Buffalo, many firms responded to the new demands of competition by cutting costs. Business abandoned its previous, painfully nurtured relationship with labor, which hinged on 'sharing the pie', linking financial prosperity to job security and high wages for workers. Lured by low wages in other countries, many firms left

> the United States altogether. Steel, Buffalo's great industry, abandoned the local population, for low wage regions.[6]

The bulk of Buffalo's working class was stunned, as low wages in the service sector replaced the high wages of the past. The new forms of employment did not provide a gateway out of poverty. Buffalo's displaced laborers found themselves having to retrain to compete with workers half their age, for a fraction of the wages they commanded before. Doctor Haynes further states,

> The more established capitalist and affluent working class families, taking cue from private sector, fled the city. Local retail was badly hurt, as large chains and malls enticed consumers from the city in record numbers.[7]

Doctor Henry Taylor, Director of the Center for Urban Development at Buffalo State College highlights the social and demographic changes of this period,

> These economic changes were mirrored by social and demographic changes, which took on ethnic and racial overtones as the vast majority of those able to flee were European-American. Not only was Buffalo getting poorer, it was getting darker: the percentage of minorities rose to nearly 40% and the total population was cut in half. The metropolitan population fell from 620,000 to 320,000 from the 1970's to the 1990's. Today, Buffalo has become one of the five most segregated cities in the country.[8]

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[6]Haynes, 17.

[7]Ibid, 21.

[8]Dr. Henry Taylor, African-American's and the Rise of Buffalo's Post Industrial Economy, (Buffalo: Buffalo Urban League, 1990) 65.

By the 1980's, the ravages of post-industrialism and white-flight to the suburbs had reduced Buffalo and other northern industrial centers to what Dr. Cornell West describes as "chocolate wastelands."[9] An infamous billboard add appearing in downtown Buffalo summed up the sad state of the city,

> Will the last worker in Buffalo, shut the lights off on the way out...

Today, Buffalo is a poor city. A 1994 report from the US Department of Commerce appearing in **USA Today** indicated that Buffalo residents with jobs have a median household income of $18,482, compared to the national figure of $30,000(ranking Buffalo 95th among 100 US cities of comparable size).[10] Twenty six percent of current city dwellers live below the poverty line, while 18.5% of metropolitan families are on welfare. Among the city's African-American population, the poverty rate climbs to a wrenching forty-one percent.[11] Essentially, what was once one of the most opportune cities in the United States for African-Americans, has become one of the most economically adverse places in the nation for African-Americans.

To a large extent, the growth and decline patterns of

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[9]Cornell West, "Black History Month Address," at University of Buffalo, February 20, 1994.

[10]David Wingate, "City Residents Becoming Poorer," USA Today, 13, October 1993, sec. A1.

[11]Haynes, 16

the city of Buffalo and First Shiloh Baptist Church have run along parallel lines this century. Both grew rapidly and prospered greatly through the first half of the century. Both reached a zenith of sorts at the mid-century point. Both have experienced severe decline in the second half of this century. By the start of the nineteen eighties, the First Shiloh congregation had fallen to just over 600 members (from the nearly 3,000 just 3 decades earlier.)

Then tragedy struck!

GROANINGS TOO DEEP FOR WORDS

On March 30, 1984, Reverend Elijah J. Echols, Jr., who had succeeded his father as the Pastor of First Shiloh since 1962, suffered a massive and fatal heart attack. Without warning, a sudden and tragic end had come to a very distinguished father-son pastoral dynasty that had endured for an amazing sixty-six years.

Following a period of mourning, the First Shiloh congregation elected a new pastor, Rev. Timothy L. Careathers, in 1985. It would be a short and stormy relationship. After only fifteen months, the new Pastor abruptly resigned in February of 1987. The events surrounding the resignation of Rev. Careathers led to the dramatic and devastating exodus of 300 members to form the Free Spirit Missionary Baptist Church. Many of them who left First Shiloh at the time of the split had been life

long members. Many family members that had worshipped together for their entire lives, now went their separate ways every Sunday morning. Weddings and funerals became occasions of fierce debate within many families as to where to have the service and which Pastor would officiate.

These events marked the lowest point in First Shiloh's long and storied history. The congregational infighting and political melee would continue for the next several years. From my vantage point as the succeeding Pastor, this wrenching period in First Shiloh's history demonstrates two things. Firstly, the depth and the power of an individual's or a community's grief. And secondly, that unhealthy grieving (or unresolved grief) can prove to be as devastating to an individual's or a community's health and well-being as was the original loss. Kenneth J. Doka, Ph.D, offers this insight,

> When individuals or communities fail to achieve resolution of their grief, then in the aftermath of their experience of loss they unnecessarily experience a state of "lostness". Which is, the emotional and psychological fragmentation that resonates destructively throughout all parts of their lives.[12]

When I began serving the First Shiloh congregation as Interim Minister in June of 1987, I quickly recognized that I had inherited both a greying and a grieving congregation in a decaying and depressed city. Of the little more than,

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[12]Kenneth J. Doka, Ph.D. Understanding Grief (Washington, DC: National Bereavement Teleconference, 1994) via Satellite at Erie Community College, Suburban Campus.

200 persons on the church rolls at the time, few were under the age of forty-five. Among the 19 members of the Board of Deacons only 5 were under the age of 60. At my July 31, 1988 Pastoral installation reception, my mother commented to me privately, "Boy, if you're going to stay here, you're going to bury half your church within 10 years!"

My mother's morbid forecast has since proven to have been amazingly prophetic. By the end of 1995, I had buried 152 parishioners as pastor of First Shiloh Baptist Church. This fact alone highlights the "crises of loss" that has challenged my pastoral ministry at First Shiloh more than any other single factor.

The term "crisis of loss" is borrowed from Dr. Edward P. Wimberly, who, in his book entitled, **African-American Pastoral Care**, uses it in his discussion of "Illness and Bereavement,"

> The "crisis of loss" is the cessation and interruption of important interacting patterns and sustained relationships which have been taken for granted. It is also a rupture in the existing narrative of life, because the experience of loss is the disruption of a narrative. The death of a loved one causes a revising of the story one has been living. For some, death means fashioning a completely new story for one's life. The crisis is personal and individual, and so is the story about it.[13]

Essentially, in the past few decades, the crisis of loss has been the defining experience in the story of the city of Buffalo, the story of the First Shiloh Baptist

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[13]Edward P. Wimberly, African-American Pastoral Care, (Nashville: Abingdon Press, 1991) 36.

Church congregation, and for the stories of persons in general in the socially volatile and economically desperate inner cities of America. The crisis becomes further compounded when the losses appear in "layers" or "series" as is often the case in my urban parish context of ministry; the loss of loved ones to death (many of which are untimely or tragic among urban African-Americans)[14]; separation from spouse, children or parent due to divorce, custody arrangement, abandonment, or incarceration; isolation from one's adult children and grandchildren who have relocated to more economically gainful cities; loss of employment and the feeling of self-esteem that is invariably attached to employment in a society like ours that is undergirded with a strong work-ethic; loss of fellowship with endeared brothers and sisters in Christ who have moved their church membership in response to congregational upheaval; even the loss of a clear and definitive congregational identity in the "post-Echols" era of the life of First Shiloh Baptist Church. The list goes on.

On so many different levels, the people whom God has given to me to minister to, have had their living narratives disrupted by the crisis of loss. So devastating have been the losses of some that they have at points become emotionally paralyzed. Their lives appear suspended

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[14]The Buffalo Police Department's Annual Report for 1994 indicates a record 97 homicides committed in the city of Buffalo in that year. That figure ranks fifth highest

in a holding pattern of despair, unable (perhaps unwilling) to reconnect with new relationships and purposeful living. I have witnessed some of First Shiloh's most seasoned and faithful members degenerate into neurotic antagonists within the congregation with no apparent explanation other than that they never finished grieving in the wake of profound personal loss.

Prominent voices within the African-American community are beginning to conclude that our youth in particular bear tragic scars from the over-exposure to death and violence so early in life. At the 1995 Buffalo Urban League Annual Banquet, William Gray, President of the United Negro College Fund suggest that,

> With each experience of death and violence, either personally or vicariously, our youth become more distant, less trusting, and more inclined toward hedonistic behavior than the day before.[15]

The emotional peril of this death and violence saturated generation of youth was brought to focus in a startling article appearing in **Jet** magazine, in January of 1994. This article reported that a significant number of

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in the nation per capita according to the FBI Uniform Crime Code. Seventy-five of the 97 victims were African-American. Futhermore, in 1988, The National Center for Health Statistics calculated that nationally, the death rate among African-Americans exceeded the death rate among white Americans by 500% in homicides, 250% in AIDS related death, and 50% in accidental deaths.

[15]William Gray, in speech entitled, Tying Our Ropes Together, at the 1995 Buffalo Urban League Annual Banquet, 1995.

the Black students attending the Elliott Junior High School in the nation's capital were formally planning their own funerals because they were not sure they would live to see their twenty-first birthday. One young girl featured in the article, Alicia Brown, at the age of fourteen had experienced the death of six of her closest friends. In the article she states,

> When a close friend of mine got killed, for no reason, I began feeling like there was no hope. Why do we have to live this way? ...You might think that its wild for a child to plan their own funeral when they haven't even lived their life... A lot of kids out there have had their childhood stolen.[16]

Disruption of the life narrative in childhood and adolescence is particularly traumatic and potentially affects permanent emotional damage. A few years ago, I had an arresting conversation on the front staircase of our church with one of our youth following the gang murder of one of her close school mates a few days earlier. The victim, a sixteen year old boy, had been the topic of discussion in Sunday School just the previous week (He was well known to many of the youth in the congregation). The youth had discussed witnessing strategies for reaching this young man and others like him "before it was too late." The sudden news of his murder a few days later stunned all of the youth, but this one young lady in particular was so devastated that she became bodily sick and in bed for three

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[16]"Black Youths Tell How Gangs and Guns Have Them Planning Their Own Funerals," Jet, 31, January, 1994, 27.

days. When I saw her sitting motionless and glassy-eyed on the church staircase following youth choir rehearsal later in the week, I inquired as to how she was doing. Her morbid comment to me was,

> Rev. it's too hard being young today...,it just don't seem worth it most of the time!

Situations like these have some voices in the African-American community arguing that many children and youth in volatile urban inner-city neighborhoods are displaying Post-Traumatic Stress Disorder {PTSD}; a condition generally exhibited by veterans of war. In her book, **Life after Vietnam**, Delores A. Kuenning writes,

> It should be remembered that {PTSD} is **not** a mental illness; it is a reaction to the extreme stress these men and women suffered during and after the war in Southeast Asia. Similar symptoms have been found in victims of car accidents, sexual abuse and child molestation, in women post-abortion, and in others who have been through natural disasters, personal trauma, or massive destruction. In other words, those who have had extremely stressful, traumatic experiences.[17]

Essentially, today, young and old alike experience death and loss in ways that exceed their emotional and spiritual wherewithal to cope.

THERE IS A BALM

It is my pastoral opinion that in the wake of a crisis of loss, grief resolution is a critical health and wellness

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[17]Delores A. Kuenning, Life After Vietnam: How Veterans and Loved Ones Can Heal the Psychological Wounds of War, (New York: Paragon House, 1990), 49.

issue that almost always requires some type of competent intervention. Grief does not resolve itself. Nor does time alone heal all wounds. The formal establishment of grief care ministry within the African-American church can prove significant in assisting grieving parishioners whose living narratives have been disrupted by death and loss. Doctor Margaret Mitchell, who established a grief care ministry at the Olivett Institutional Baptist Church in Cleveland, OH, argues that,

> The African-American church is an excellent place to help members of the African-American community deal with death, dying, grief, the grieving process, and grief recovery. Why? The African-American church has had the historical precedent of grappling with these issues.[18]

Throughout the decades and centuries of our African-American odyssey, the Black Church has been the institutional mainstay and the trusted service provider. Many of our people remain cynical and suspicious of other therapeutic service providers even when they are legitimate and reputable outfits recommended by their Pastor. They turn toward their church for help and healing of their wounded psyches and souls.

Thus, the African-American church should accept the challenge to retool in order to establish effective grief care ministries within the body of Christ. The size of most progressive urban churches of today preclude the possibility

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[18]Margaret Mitchell, Grief Care Ministry, (Ashland Theological Seminary, D.Min Project, April, 1994), 32.

of effective grief care being provided solely by the Pastor and ministerial staff. Such is the case at First Shiloh. With a growing membership of 700 plus, a genuine priestly response to the need for grief intervention requires the development of a shared ministry between ministerial staff and the men and women of the Deacon and Deaconess ministries.

Doctor Mitchell challenged the African-American church not to "...merely bury its dead, it must learn how to **care** for its dying and grieving."[19] The very purpose of this project is to develop a model whereby a church can train its leaders to provide the critically necessary care for its members in their crisis of loss.

Fifty years ago First Shiloh Baptist Church of Buffalo, New York established as its motto, "A church with a ministry of love." No higher motto could ever by adopted. At First Shiloh we believe that empowering people to assist the bereaved in the painful task of working through their grief and revising their living narrative is one of the many significant ways that love ministers.

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[19]Ibid, 33

CHAPTER TWO

Death belongs to life as birth does. The walk is in the raising of the foot as in the laying of it down.
Tagore, from "Stray Birds" CCCXVII

INTRODUCTION TO MODEL

This "model-in-ministry" project constitutes a practical approach to training deacons and lay leaders to provide effective grief care to members of the local church. It aims to relieve the Pastor and his or her ministerial staff of sole responsibility for ministering to bereaved members of the body of Christ: to established a shared ministry of grief care that can provide broader coverage, faster response, and more thorough assistance to church members in their times of loss.

In the main, this project concerns itself with:

1) Providing members of the diaconate with a clear understanding of what grief is and how it works.
2) Teaching the deacons the principles of grief counseling.
3) Training deacons to better function as liaisons between the church and bereaved families in preparation for funerals, and wakes.
4) Teaching deacons to know when to refer bereaved persons back to the Pastor or other professional care givers.

The Participants in this model-in-ministry project were twenty members of the Deacon and Deaconess Boards of the First Shiloh Baptist Church, and ten other members at large who were interested in (or at least curious about) ministering to the grieving. Their ages ranged from twenty-seven years of age to seventy-seven years of age. Educational levels of the participants spanned from the fourth grade to the PhD.

Though many of the participants have been functioning in the diaconate ministry and church leadership for decades, this project made no assumptions as to anyone's level of knowledge regarding the subject of grief or the adequacy of anyone's present methods of consoling grieving persons. Each participant was administered a pretest designed to identify their present understandings of what grief is and what were their present methods of assisting grieving persons. See pages 136-140 for full text of pre-test questionnaire.

After administering the pretests, the participants attended a six-session grief training course that instructed them in:

1. Grief theory
2. Diagnosing symptoms of normal and abnormal grief reactions.
3. The goals and principals of Grief Counseling
4. Strategies for intervention (funeral to follow-up)

After the conclusion of the training series, post tests were administered to measure any growth in the participants knowledge of the subject of Grief, their grasp of the strategies for intervention, and their level of comfort about the ministry to grieving persons. See pages 141-145 for full text of post-test questionnaire.

UNDERSTANDING GRIEF

The basis of grief is attachment. That is, the tendency in human beings to make strong affectional bonds with others. British psychiatrist, John Bowlby, pioneer researcher and writer in the area of grief and loss, says that,

> ...these attachments come from a basic need for security and safety: they develop early in life, are usually directed toward a few specific individuals, and tend to endure throughout a large part of the life cycle... Essentially, attachment behavior has survival value.[1]

William Worden, professor of psychology at the Harvard Medical School explains grief as "the strong emotional reaction that occurs when those [affectional] bonds are threatened or broken."[2] Doctor Mivalima Imara, Associate Professor of Community Health and Preventative Medicine at Morehouse School of Medicine in Atlanta, Georgia, refers to

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[1]John Bowlby, "The Making and Breaking of Affectional Bonds," British Journal Psychiatry (1977) 130.

[2]William Worden, Grief Counseling and Grief Therapy, (New York: Springer Publishing Company, 1991) 7.

grief as,

> ...the characteristic pattern of psychological and physiological responses a person makes following the death of a significant person.[3]

The manifestations that individuals experience in grief can vary widely. Physical symptoms can include headaches, dizziness, exhaustion, muscular aches and lack of muscular power, menstrual irregularities, sexual impotence, loss of appetite, tightness of throat, insomnia, breathlessness, tremors and shakes, and over-sensitivity to noise, to name a few.

Other grief manifestations are affective or emotional. These may include anger, guilt, anxiety, feelings of helplessness, sadness, shock, yearning for the deceased, numbness, and self-blame. Some bereaved persons experience a sense of relief or even a feeling of emancipation. Generally speaking, this occurs when death concludes a long and difficult illness, or in the cases of the death of abusive, domineering or troublesome loved ones. This, however, may be followed by a sense of guilt. As in many situations of emotional crisis, contradictory feelings such as a sadness and relief can be experienced at the same time.[4]

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[3]Mivalima Imara, "Growing Through Grief" in Hospice Care: Principles and Practice, Charles A. Corr and Donna M. Corr, ed., (New York: Springer Pub. 1983) 258.

[4]Brian Lindstrom, "Exploring Paranormal Experience of the Bereaved.", Presented at the Fifth Annual Conference of the Forum for Death Education and Counseling (September, 1982) 9.

Cognitive or mental manifestations of grief are also extensive. These include an inability to concentrate, confusion, idealization of the deceased, preoccupation with the image of the deceased (ie, pictures, etc.) and dreams of the deceased. In a paper entitled, "Exploring Paranormal Experience of the Bereaved," Brian Lindstrom confirms,

> A number of studies have shown that many bereaved persons may experience, a vague or dramatic fleeting auditory, visual, olfactory, or tactile hallucinatory experiences. Most bereaved persons interpret such experiences positively as reassuring signs that the deceased person will be near them, or is happy and at peace, or that they themselves should continue with their lives. In some cases, however, experiences of 'presence' are perceived negatively. Typically, negative experiences of presence occur when the bereaved was on less than ideal terms with the deceased at the time of death or other 'toxic' history with the deceased remained unresolved.[5]

Simply put, grief is trauma resulting from an experience of detachment or the anticipation of detachment. The trauma impacts the whole person of the bereaved. In the book, "A Time to Grieve," social worker Bertha Simos makes the following comparison between physical illness and grief,

> Both may be self-limiting or require special intervention by others. And in both, recovery can range from a complete return to the pre-existing state of health and well-being, to partial recovery, to improved growth and creativity, or both can inflict permanent damage, progressive decline and even death.[6]

Until recently, the terms "grief," "bereavement," and "mourning," were used almost interchangeably. Today,

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[5]Lindstrom, 15

[6]Bertha G.Simos, A Time to Grieve. (New York: Family Service Association, 1979) 30.

scholars and clinicians, offer distinct definition of each. Kenneth J. Doka, Ph.D., Professor of Gerontology at the graduate school of the College of New Rochelle, New York, and President of the Association for Death Education and Counseling, offers these distinctions,

> Bereavement can be defined as an objective state of loss, or a change of status resulting from loss. Bereavement, then, refers only to the basic fact of loss, while grief refers to the individual's response or feelings regarding that loss. One can grieve without having been bereaved, as for example, in the case of anticipatory grief. Similarly, one can be bereaved yet not experience grief, as, for example, in situations in which the survivor has little or no emotional response to the death.
>
> "Mourning" can be defined as the culturally patterned expressions or rituals that accompany loss and allow others to recognize that one has become bereaved. Wearing black and attending funerals are examples of mourning behaviors. Again, though, one can mourn without experiencing grief, or grieve without mourning. For example, a newly divorced person may experience a profound sense of grief, but there are few rituals or behaviors through which the feelings of loss can be expressed to others.[7]

Wimberley offers a capsulized distinction between the terms,

> Bereavement is the sudden cessation of a close and abiding relationship. Bereavement often elicits negative emotions called grief. Mourning comes after the death of a person who has had a particular place in one's life. This follows a somewhat characteristic pattern as the bereft try to fill a void made in their lives by this loss.[8]

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[7]Kenneth J. Doka, "Grief," in Encyclopedia of Death, R. Kastenbaum and B. Kastenbaum, Eds. (Phoenix: The Oryx Press, 1989) 8.

[8]Edward P. Wimberley, African-American Pastoral Care, (Nashville: Abingdon Press, 1991) 37-38.

THE NEED FOR GRIEF CARE

A legitimate criticism of past practices in pastoral care for the bereaved has been that the church withdraws its support following the funeral. Reverend Kevin E. Ruffcorn, confesses in his article, "Grief Aftercare," that,

> We, parish pastors usually have a significant pre-death ministry with families. Then we bow out after the funeral service. I have learned that the funeral or memorial service is not the place to terminate ministry, but rather a place to begin a different type of ministry-grief aftercare.[9]

It is my general impression that, the local parish has not been intentional enough with the provision of structured and effective aftercare for bereaved members. Perhaps in part due to a lack of understanding of the duration of the grief process. Many persons have been "taught" in their churches to "be strong" following a death, which, practically speaking, has translated into a sort of benign social pressure on the bereaved to repress any mourning-like behavior not too long after the funeral, lest one be accused of not adjusting very well for the sake of their ongoing observable mourning. In the book, **The Courage to Grieve: Creative Living, Recovery, and Growth Through Grief**, Judy Tatelbaum highlights the critical nature of the "extended" time period following a death,

> Whenever we lose a loved one, we grieve: for weeks, for several months, or even for a period of years. This time for grieving is called the mourning

[9]Kevin E. Ruffcorn, "Grief Aftercare," Leadership: A Practical Journal for Church Leaders 10, no. 4 (Fall 1989) 38.

> period, first described by Sigmund Freud in his 1917 paper, "Mourning and Melancholia." Although there is no set time, many cultures and religions designate one year for mourning...[10]

Mivalima Imara argues for a much longer mourning period,

> Most people, about 80% to 90%, move through grief to recovery in a satisfactory manner within **2** to **4** years following a death.[11]

All voices in the study and the treatment of grief agree that a grief response is a very individualized and idiosyncratic thing. The intensity, duration and character of a grief response is determined by a multiplicity of factors that preclude the establishing of any rigid time frame for the completion of an individual's grief work. Rather than being concerned with resolving grief in a certain time frame, the concern is instead placed upon assisting the bereaved with the completion of what is generally referred to as the "tasks of mourning." To this we now turn our attention.

THE TASK OF MOURNING

Mourning is generally understood as the process by which the bereaved adapt to their loss. In the book, **Grief Counseling and Grief Therapy**, Worden says that,

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[10]Judy Tatelbaum, The Courage to Grieve: Creative Living, Recovery, and Growth Through Grief (New York: Harper and Row, 1980), 21.

[11]Imara, 253.

> After one sustains a loss, there are certain tasks of mourning that must be accomplished for equilibrium to be re-established and for the process of mourning to be completed.[12]

Mourning is a process not a state. Like all process', there are certain tasks that must be accomplished before mourning has been completed. Worden identifies four tasks of mourning:

Task I - Accept the reality of the loss.

Task II - Work through the pain of the loss.

Task III - Adjust to an environment in which deceased is missing.

Task IV - Emotionally relocate the deceased and move on.

Regarding Task I - Accepting the reality of the loss, Worden explains,

> Whenever a loved one dies, something in us wants to believe that it has not really happened. The first task of grieving is to come to terms with the reality that the person is dead, that the person is gone and will not return. Reunion with the deceased is not a possibility, at least not in this life.[13]

A biblical example of the completion of task I is seen in II Samuel 12: 23, where David speaks to his servants regarding his deceased child, "...he [the child] shall not return to me.[14]" At issue here is the mental health of the bereaved. "To deny the reality of the loss can lead to anything from slight distortion to full blown dilusion in

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[12]Worden, 10.

[13]Ibid, 11.

[14]II Samuel 12: 23, Holy Bible (NRSV)

the thinking of the bereaved."[15]

In, **The Road Less Travelled**, M. Scott Peck offers a relevant insight in his discussion of the dangers of avoiding the reality of problems,

> The tendency to avoid problems and the emotional suffering inherent in them is the primary basis of all human mental illness. Some of us will go to quite extraordinary lengths to avoid our problems and the suffering they cause, building the most elaborate fantasies in which to live, sometimes to the total exclusion of reality.[16]

Carl Jung stated in succinct and elegant words that,

> "Neurosis is always a substitute for legitimate suffering."[17]

But the substitute itself ultimately becomes more painful and more problematic than the legitimate suffering it was designed to avoid. Scott adds,

> The neurosis itself becomes the biggest problem. To avoid problems and the pain they bring is to also avoid the growth that problems demand from us. It is for this reason that in chronic mental illness, we stop growing, we become stuck, and without healing, the human spirit begins to shrivel.[18]

In my opinion, avoiding the reality of loss is similiar to avoiding the reality of other problems. As such, the avoidance of the reality of a loss can also lead to the

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[15]Worden, 12.

[16]M. Scott Peck, The Road Less Travelled (New York: Simon & Schuster, 1978) 17.

[17]Carl G. Jung, in Collected Words of C.G. Jung, by R.F.C. Hull, (Princeton, NJ: Princeton University Press, 1973) 75.

[18]Peck, 18.

exclusion of reality. An example of such exclusion could be keeping the body at home several days after death.

On Task II - To work through the pain, Worden explains that,

> Those who suffer grief sometimes want to avoid the pain associated with the grief experience. But it is necessary to acknowledge and work through the pain associated with the loss or it will manifest itself through some symptoms or other forms of aberrant behavior.[19]

Imara speaks to the potential long term detriments to the bereaved on this matter,

> I believe that each of us could move through our grief, doing our grief work far more effectively, if we acknowledged squarely the depth of the pain we experience. Fewer people would then develop chronic psychological and physiological health problems.[20]

According to Erich Lindemann,

> After many attempts on the part of the bereaved to avoid that pain, the grieving process itself must be accepted if adequate mourning is to take place. Once the grief process is accepted, the bereft begin to deal with the memory of the deceased person, and this, in turn, is followed by relief in tension.[21]

Task III - To adjust to an environment in which the deceased is missing - reckons with the domestic and social ramifications of the loss to the bereaved. Worden writes,

> Approximately three to four months following the death the bereaved begin to learn in full what it practically means to experience life without the

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[19]Worden, 14.

[20]Imara, 253

[21]Erich Lindemann, "Symptomatology and Management of Acute Grief," Crisis Intervention, ed. Howard J. Parad (New York: Family Service Association, 1976) 20.

> deceased around. The survivor usually is not aware of all the roles played by the deceased for some time after the loss occurs.[22]

C.M. Parks makes an important point on this matter of adjusting to an environment where the deceased is no longer present,

> In any bereavement, it is seldom clear exactly what is lost. A loss of a husband, for instance, may or may not mean the loss of a sexual partner, companion, accountant, gardner, baby minder, audience, bed warmer, and so on depending on the particular roles normally performed by this husband.[23]

From my own pastorial experience, I have observed that the challenge of developing new skills for daily survival in one's immediate environment and taking on new roles because of the absence of the deceased is difficult for all survivors and resented by many. But the failure to complete this third task of grieving is to relegate oneself unnecessarily to some state of helplessness.

Finally, Task IV - is to emotionally relocate the deceased and move on with life.

Worden states that this fourth task of mourning is to "withdraw emotional energy from the deceased and reinvest it in another relationship."[24]

The bereaved may struggle with task IV from the basis of loyalty to the deceased. For many bereaved persons,

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[22]Worden, 17.

[23]C.M. Parks, Bereavement: Studies of Grief in Adult Life, (New York: International University Studies, 1972) 7.

[24]Worden, 16.

investing in new relationships at first feels like an act of betrayal to the deceased. In the article, "**Treatment of Spousal Bereavement**," S.R. Schucter and S. Zisook are helpful in reconciling the need to remain loyal to the deceased and the need to go on with one's own life,

> A survivor's readiness to enter new relationships depends not on "giving up" the dead spouse but on finding a suitable place for the spouse in the psychological life of the bereaved - A place that's important but that leaves room for others.[25]

A good contemporary example of the completion of task IV is Rev. E.V. Hill's treatment of his deceased first wife's memory now that he has remarried. In a 1991 appearance at the Buffalo Convention Center, Reverend Hill remarked in his opening comments that, "I've got a good wife in Glory and a good wife beside me here on Earth."[26]

When is mourning over?

A general survey of the literature concedes that mourning is over when the tasks have been completed and the bereaved can think of the deceased without pain (though there may be sadness!)

Following the sudden and fatal heart attack of Rev. Elijah J. Echols, Jr., a black sheet remained draped over

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[25]S.R. Schuchter and S. Zisook, "Treatment of Spousal Bereavement", Psychiatric Annals, (1986) 295-305. 20Worden, 16.

[26]E.V. Hill, in Sermon entitled, Why I Want To Go To Heaven, delivered at the Buffalo Convention Center, Buffalo, NY, February 23, 1991.

the Pastoral chair in the First Shiloh pulpit for a year. This act suggested that the congregation was in mourning. On the anniversary of Rev. Echols's death, a special memorial service was held to remove the black sheet and to pronounce the mourning period over. A senior Pastor from a nearby sister church presided at the service. When time came to remove the mourning cloth, a sudden snatching away of the cloth occurred. This sent many of the more senior members of the congregation into somewhat of a state of shock and outrage. The abrupt gesture of the visiting pastor certainly could have been perceived as insensitive. However, in the end, the real trauma may have been that while the mourning period was declared "officially" over, many in the congregation had not completed all of its tasks.

Regarding mourning, Wimberley states,

> The basic tasks [of mourning] for the bereaved person are to achieve emancipation from bondage to the deceased, readjust to a world in which the deceased is missing , and form new relationships. Another task is to revise and edit one's life story without the deceased.[27]

THE GRIEF PROCESS

The grief process should be considered from the vantage point of both the terminally ill and that of the bereaved survivors of the deceased or dying. Generally speaking, the stages of the grief process remain fairly similar in both respects. However, there are notable points of departure.

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[27]Wimberley, 38.

Twenty five years following the original publishing of, **On Death and Dying**, Elisabeth Kubler-Ross continues to be the focal point of discussion of grief and terminal illness. Kubler-Ross identifies five definitive stages that the grief of the terminally ill moves through,[28]

Stage One: DENIAL

Denial is a temporary defense that functions as a buffer after unexpected shocking news. Kubler-Ross explains that,

> Denial allows the terminally ill to collect themselves and, with time, mobilize other, less radical defenses. Essentially, denial is a state of shock.[29]

Stage Two: ANGER

Here, the patient's anger is displaced in all directions and projected onto the environment at times almost at random. This stage of anger is very difficult to cope with from the point of view of the dying's family, caretakers, and any medical staff that may be attending to them.

Stage Three: BARGAINING

The bargaining is really an attempt to postpone. The dying may attempt to "nicely" ask God for some reprieve which previously was "demanded" in anger.

Stage Four: DEPRESSION

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[28]Elisabeth Kubler-Ross, On Death and Dying (New York: Macmillian Publishing Co. 1969) see chapters 3-7.

[29]Ibid, 35.

This stage essentially is the release of raw sorrow in response to sober contemplation of the fact of being terminally ill. Kubler-Ross comments,

> The dying person should not be asked to consider the sunny side of things, for if they are allowed to express their sorrow they will find a final acceptance much easier.[30]

Stage Five: ACCEPTANCE

Acceptance should not be mistaken for a happy stage. It is almost void of feelings. Here the terminally ill have come to terms with the inevitable and begun to make incremental, emotional divestment from this life. This is a time where usually the family needs more help, understanding, and support than the patient themselves, because the family may interpret the patients emotional divestment from this life as rejection of them.

From the vantage point of the bereaved survivors, Wimberley presents the grief process in three stages,

> Normal grieving is characterized by three phases. First, the grief sufferers yearn for the lost loved ones and experience anger toward the loved ones for abandoning them. The second phase begins when the bereaved accept the fact that neither yearning nor anger will bring the loved ones back. This leads to despair and disorganization in the lives of the bereaved. Following this phase is a period of reorganization, in which the bereaved turn toward the world and begin to find new relationships and meaning in life. During this period, the grief sufferers either begin the task of revising and editing the old story or begin to develop a new story without the deceased.[31]

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[30]Ibid, 77.

[31]Wimberley, 40.

Both the dying and their bereaved survivors experience grief in response to the anticipated death and in response to the actual death. The initial stages of the grief process may be very similiar for both (ie., denial, anger, depressions, etc.) However, it is in the final stages of the grief process that the needs and the challenges of the dying vs those of their survivors, move in distinctly different paths. As I already pointed out, in Kubler-Ross' fifth and final stage of grief for the terminally ill, the dying person begins to make incremental emotional divestment from this life. To the contrary, in both the third and final stage of Wimberley's grief process for the bereaved and Worden's fourth and final task of mourning for the bereaved, survivors are re-investing in life and in new relationships. Thus, the grief work for the terminally ill and the bereaved, respectively, moves toward different ends, and accordingly involves different tasks.

Persons involved in grief-care ministry must always keep in mind that the grief reaction of any given individual is highly personal and idiosyncratic. And as persons move through the grief process, how they experience their loss and how they express (mourn) their loss in public is not a simple measure of their love and devotion to the deceased, but is the outcome of many interesting factors. In the handbook, **Living with Grief: Personally and Professionally**, Kenneth Doka identifies several factors which influence the

nature of the bereaved's grief reaction, including[32]:

* The Bereaved person's unique relationship with the deceased.
* The strength of the attachments.
* The degree of ambivalence and unfinished business in the relationship.
* The circumstances of death, including the length and the nature of the illness, the preventability of the death, the conditions of the death.
* Reactions to previous loss.
* The personality and coping behaviors of the bereaved person.
* The bereaved person's ability to express emotions and seek and receive help.
* Social variables such as the strength and nature of the family system.
* The presence and nature of informal support systems, cultural and religious beliefs and practices.
* General health and lifestyle practices.

In the article, "Grief: Normal and Pathological Variants," Milton Viederman, M.D., writes:

> The problem of attachment and loss is so central to the human condition and dependant on so many factors that its forms are protean and elucidation often difficult. Such factors as suddenness of loss, certainty of loss (e.g., soldiers missing in action), form of death (suicide, murder), and role relationships

[32]Kenneth J. Doka, Living with Grief: Personally and Professionally, (Washington, DC: Eisenberg Associates, 1994) 11.

> all play a role in the experience of loss and the variety of grief responses, normal and pathological.[33]

Because no two people's grief reaction can be exactly the same, neither is the manner in which any two bereaved persons resolve their grief ever exactly the same. Earlier observers like Kubler-Ross looked at the grief process as though it were a series of general stages beginning, for example with denial (shock) and ending with acceptance. Building on those insights, more recent writers such as Imara, Parks, Worden, Doka, Lindstrom and others, have emphasized that the bereaved must complete certain tasks during the mourning process. Parks says that,

> the advantage of this kind of 'task model' is its recognition that individuals may complete these tasks in different sequences and at different rates, a fact that the Grief counselor must be careful to always bear in mind.[34]

WHAT IS GRIEF COUNSELING

Grief counseling involves helping people facilitate normal (or uncomplicated) grief to a healthy completion of the tasks of grieving within a reasonable period of time. Grief counseling is a distinct practice from grief therapy, which involves the use of specialized techniques to help people with abnormal or complicated grief reactions.

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[33]Milton Vierdetman, "Grief: Normal and Pathological Variants," American Journal of Psychiatry,(January 1995) 3.

[34]C.M. Parks, "Bereavement Counseling: Does it work? "British Medical Journal, (1980) 6.

In, **Bereavement Counseling: Does It Work?,** Colin Parks says that,

> ...both professional services as well as volunteer peer groups with professional support are capable of reducing psychiatric and psychosomatic disorder resulting from bereavement.[35]

The overall goal of Grief counseling is to **help the bereaved to complete any unfinished business with the deceased.**

According to Worden, "Whatever one's philosophy about grief counseling and whatever the setting, there are certain principles and procedures that help make grief counseling effective."[36] The following are Worden's guidelines to assist the grief counselor in that process:

* **Principle One: Help the Survivor actualize the loss.**

The Grief Counselor must help the bereaved person come to terms with the reality that the loss has actually occurred. A primary technique is to get the person to talk about the loss. The counselor might ask, "Where did the death occur? How did it happen? Who told you about it? What was the funeral like?

* **Principle Two: Help the Bereaved to identify and express feelings.**

The Grief Counselor must encourage the bereaved person to express their feelings despite what they are, including -

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[35]Ibid, 4.

[36]Worden, 42.

anger, quilt, anxiety and helplessness.

* **Principle Three: Assist living without the bereaved.**

The Grief Counselor must help the bereaved person accommodate the loss by encouraging them to make independent decisions. Practical problem solving approaches that are sensitive to the bereaved's particular circumstances are extremely helpful here.

* **Principle Four: Facilitate emotional withdraw from the deceased.**

The Grief Counselor must encourage the bereaved person to form new relationships. In the case of the loss of a spouse, some people may be hesitant to form these new relationships because they believe this will dishonor the memory of their departed spouse.

* **Principle Five: Provide time to grieve.**

Grieving requires time - Each birthday and anniversary can bring back special memories and a sense of loss. The grief counselor must be careful not to rush the bereaved person, and instead, encourage then to honestly experience the feelings (often conflicting) that those days bring. This is a very important part of the healing process.

* **Principle Six: Interpret "normal" behavior.**

Many bereaved persons think that they are "going crazy" because of the emotional turmoil that they feel. The Grief Counselor helps the bereaved to understand and interpret "normal" grief reactions.

* **Principle Seven: Allow for individual difference.**

As previously stated, the behavioral responses to grieving are many. If one family member deviates from the rest in their behavior, the Grief Counselor must encourage the family **not** to upset this person's need to express their grief differently.

* **Principle Eight: Provide continuing support.**

The idea here is for the Grief Counselor to be spontaneous as well as to be calculating in extending support. For example, if a person has lost a mother and Mother's Day is approaching, this may be a time to offer additional support and comfort.

* **Principle Nine: Examine defenses and coping styles.**

The Grief Counselor must help the bereaved to recognize defenses that they consciously or unconsciously put in the face of their loss. As well, the Grief Counselor must help the bereaved to identify coping styles that may help them along in completing their "grief work."

* **Principle Ten: Identify pathology and refer.**

The Grief Counselor must always be mindful of their limitations and know when the symptoms being displayed are beyond their expertise. A good (and wise) counselor is never afraid to confer with professionals or to refer to professional sources.

CHAPTER THREE

BIBLICAL AND THEOLOGICAL FOUNDATIONS

Bear one another's burdens, and so fulfill the law of Christ.

Galatians 6: 2

In Galatians 6: 1-10, the Apostle Paul addresses the matter of the Christian life in its responsibility to others. It is a continuation of a discussion he begins in 5: 13-15 where he promotes the idea of loving service to others as a chief characteristic of Christian liberty. Linking liberty and love, Paul lays the foundation for the ethic of mutuality in the relations of the saints,

> Brothers, you were called to freedom, only do not use your freedom as an opportunity for the flesh, but through love be servants of one another. (5: 13)

Paul knew well the potential dangers of freedom to the health and the well-being of the individual and the community. Even Christians "bite and devour one another" (5: 15), fall prey to conceit and envy, and provoke one another (5: 26). However, Paul took departure from the conservative Jewish persuasion that freedom would inevitably destroy community. According to Carolyn Osiek,

> Paul understands freedom not as the opportunity to pursue one's own interests, but to be even more at

the service of others.[1]

Paul extends the discussion of the principle of mutual love into chapter six, and makes direct application of what has preceded to the Galatian's corporate life. Here Paul levies the injunction to "Bear one another's burden," in direct reference to the case just mentioned in 6: 1 where a Christian falls to a surprise temptation. Immediately, other mature Christians ("ye who are spiritual"), being careful not to join the chorus of critics, are to seek ways and means of restoring the fallen brother or sister. His or her burden has become theirs. Consistent with the Apostle's signature illustration of the church as a body (cf. 1 C. 12: 12 ff.), he reasons that what affects one member must affect the whole. Conversely, the whole takes responsibility for the welfare of any one of its members.

The general injunction to bear one another's burdens, however, broadly applies to any and all burdens that a person might be "surprised" by (ie., sorrow, sickness,

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[1]Interestingly, Osiek also cautions that, "this ideal of service and even self-sacrifice poses definite problems for women of all generations and nearly all cultures who are socially educated to expect that their true happiness lies in service to others, while men are brought up to pursue their own goals. Bearing the cross in freedom does not mean enduring abuse and victim-hood, but living genuinely for others out of one's own inner freedom by claiming the inheritance of the "sons of God!" Carolyn Osiek, "Galatians," The Women's Bible Commentary, Carol A. Newsome & Sharon H. Ringe, eds., (Louisville: Westminster John Knox Press, 1992) 336.

destitution, foe, fear, etc.).[2] Regardless of the particular burden, Christian's responsibilities toward one another remain the same.

With the use of the greek word ***Prolambano***, (eng., "overtaken") in 6: 1, Paul aims to heighten his reader's sense of the vulnerability of the fallen brother or sister to their particular burden. A literal meaning is "to ambush," or, "to take by surprise." Certainly in the case of bereavement, the element of "surprise" is a common experience. No one can "know the day or the hour" that death will sneak around some unsuspecting corner. One can not help but to feel pity for unsuspecting persons who are suddenly crushed with the news of a loved one's fatal heart attack or stroke, car accident, murder, drug overdose, suicide, or even sudden infant death (SIDS) or still-birth. Even in the event of a medically expected death of an elderly loved one the emotional response is still that of "unreadiness."

In addition to his use of ***Prolambano***, Paul makes it obvious to his readers why mutuality is so vital within the body of Christ with the word ***Bare*** (eng., "burden"), in 6: 2. ***Bare*** points to the heavy, crushing load -- more than a person could be expected to carry without help. Negatively stated, there are some burdens that a particular Christian

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[2]Donald Guthrie, Galatians (NCBC), (Grand Rapids: Eerdmand, 1989) 43.

under certain circumstances cannot reasonably be expected to carry alone. Positively stated (and more instructive for our purposes here), potentially overwhelming burdens become manageable for hurting saints with the compassionate intervention of fellow Christians.

What the Apostle emphatically raises here as the standard for interpersonal responsibility among the saints can be hung on two words. The first is "compassion." The word compassion is derived from the Latin words *pati* and *cum*, which together means "to suffer with." Henri Nouwen writes,

> Compassion asks us to go where it hurts, to enter into places of pain, to share in brokenness, fear, confusion, and anguish. Compassion challenges us to cry out with those in misery, to mourn with those who are lonely, to weep with those in tears.[3]

Nothing is more needful to grieving persons than compassion. In the time of grief and loss sorrow threatens to overwhelm, particularly when it appears suddenly, unexpectedly and tragically. If left unaided beneath the burden of grief, many persons become emotionally overwhelmed, and even physically deteriorate. Grief may become complicated or pathological. Though the burden belongs to one, the one, **alone**, may not be able to carry it. They need a compassionate "burden bearer" to step-in and share the load, thereby making it manageable. Kraig Koester writes,

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[3]Henri Nouwen, Compassion: A Reflection on the Christian Life. (New York: Doubleday, 1983) 4.

> It is precisely through God-given freedom that Christians now have the opportunity to exercise mutual love: compassion, care, and nurture for those of the household of faith.[4]

This point leads me to the second critical word involved here. Namely, intervention. The injunction "to bear one another's ***Bare***" is the expression of an interventionist praxis for the consolation and restoration of fallen saints. This same interventionist praxis is seen at work in a pivotal pericope, James 5: 14-15,

> Is anyone among you sick? Let them call for the elders of the church and let them be prayed for, and anointed with oil in the name of the Lord: and the prayer of faith will save the sick, the Lord will raise them up; and if they have committed sins they will be forgiven.

While it is unmistakably clear here, that the calling for the elders is pursuant to the desire for a divine healing, nonetheless, it is equally clear here that an agent of God must intervene even to facilitate the prayer of faith. Thus, intervention is the responsibility of community. Compassion is the essence of community.

Compassion is necessarily interventionist. Too often compassion is understood passively, from a position of disengagement. This amounts to little more than sympathy. However, many sympathetic persons fail to **act** affirmatively toward a brother or sister who has fallen beneath a ***Bare***. In the article, "Burden Bearing and the Recovery of Hurting

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[4]Kraig Koester, "Opportunity to do Good: The letter to the Galatians," Word and World (Spring, 1989) 183.

and Offending Christians," D.B. Garlington suggests there are two primary ways that the onus of burdens are to be born,[5]

> 1. In the first place, to "bear another's burdens" means to get involved with the difficult circumstances occasioned by the "burden." Sometimes of course, these problems are intricate and extreme where people are broken. Yet fulfilling the law of Christ may require involvement to this degree -- this is love going into action.
>
> 2. In the second place, we are to bear with the person. Person's burdens are not lifted overnight. Since recovery is not an instantaneous process, we must be willing to **forebear** the person who may remain broken for a lengthy period of time. Our actions must show broken persons that they are not abandoned by Christ or by us.

Doug Manning resolves that "bereaved persons manage their grief much better (and grieve much healthier) when they've had the benefit of a compassionate hand or two."[6]

Within this interventionist praxis, the weight of an individual's or a families' sorrow is proactively spread upon the broad shoulders of the caring community.

To do this, Paul continues, "fulfills the law of Christ." In contrast with the Mosaic system of legalism as a religious principle, the "law of Christ" involves voluntary (and mutual) submission to the human needs of

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[5]D.B. Garlington, "Burden Bearing and the Recovery of Hurting and Offending Christians," Trinity Journal (1991) 160.

[6]Doug Manning, Comforting Those Who Grieve, (San Francisco: Harper Press, 1987) 64.

persons rather than to a code.[7] "Of course," Gutherie comments, "love takes the sting out of this new kind of obligation."[8]

In my grief intensive context of ministry, the law of Christ compels us to elevate our ministry to the bereaved in our midst. To train Deacons to assist the Pastoral staff in this needful service is to empower them to traffic redemptively into the pain, anguish, and sorrow of the families that are assigned to their spiritual care. This ministry of "coming alongside" the bereaved brother or sister is a labor of love that aims to make another's grief and sorrow a manageable affair. We have been set free to be of such service to one another in love.

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[7]C.B. Cousar, Galatians (Interpretation) (Philadelphia: John Knox, 1982) 150.

[8]Gutherie, 134.

CHAPTER FOUR

THE PROCESS

I share with you the agony of your grief, the anguish of your heart finds echo in my own.[1]
Howard Thurman

This chapter gives the step-by-step methodology used for the development and the implementation of this project at the First Shiloh Baptist Church of Buffalo, New York.

COVENANT

I have always held that authentic ministry is that which responds to the real human condition at hand. Need defines service. Accordingly, my project focus is an attempt at an authentic pastoral response to a grief intensive context of ministry.

However, while I consider the development of effective grief care ministry a "pastoral" response, of necessity it would manifest itself as a "shared ministry" between the pastor and the men and women of the Deacon and Deaconess boards of First Shiloh. Adequate coverage of a 700 member congregation could not be accomplished otherwise.

[1]Howard Thurman, Meditations of the Heart. (New York: Harper and Row, 1953) 211.

Pastor T. Parrish of Bethel Evangelical Lutheran Church of Bellbrook, Ohio describes what tragically occurs in the absence of structured shared-ministry,

> The need for a systematic approach to lay ministry and caring for the needs of one another became apparent when several members experienced death in their families. One member was prominent, involved, and visible in her activities. When a member of her extended family died many members of Bethel took time from work to attend the funeral, which was conducted across town in another Christian congregation. A second prominent member also experienced a death in the family and the same outpouring of love and ministry was apparent. A third member, less prominent, somewhat of a problem in the past, lost a family member in his extended family. Not one member of Bethel visited the funeral home or attended the funeral service. This was a deep blow to me as the pastor of Bethel. I recognized that unless we were organized to minister systematically and given specific responsibility for the spiritual care of all, some would be overlooked.[2]

Hence, the very first task of this process was that of covenanting with these very precious men and women to become partners in this endeavor. Without their full and active support this project would have no possibility of success.

The formal act of making covenant between Pastor and diaconate took place at the regularly scheduled monthly diaconate meeting in February of 1994. First I shared my pastoral objective of providing our congregation with a more aggressive grief care ministry and to do some specialized training with the members of the diaconate toward that end. I then explained to them how my expressed pastoral objective related to my pursuit of the Doctor of Ministry degree at

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[2]Melvin J. Steinbron, Can The Pastor Do It Alone? (California: Regal Books, 1987), 203-204.

the United Theological Seminary. I explained that my model-in-ministry project would consist of the development and implementation of a model for training the diaconate to provide grief care ministry in the local church.

My presentation was received enthusiastically by those present. After a short discussion of the "how's" and "when's" and the "what ifs," the men and women of the First Shiloh Diaconate covenanted with their Pastor to be supportive in all things necessary for the completion of the proposed model-in-ministry project. The following project goals were adopted,

1. To develop a shared ministry of grief intervention between the Pastoral staff and the Diaconate
2. To enhance the competence of both the Pastoral staff and the Diaconate to provide quality grief intervention to individuals and families through out the congregation.
3. To provide bereaved persons in the congregation with more immediate, personalized, and thorough support from their church in their time of loss and sorrow.

With covenant in hand (so to speak) I had the support to proceed to the next phase of the process.

PREPARATION

In order to establish an effective model for training the Diaconate to provide grief care, it was necessary for me to familiarize myself with an almost completely foreign academic discipline. My undergraduate study was in

sociology. My seminary training focussed upon the study of "applied theology" (ethics). Prior to this Doctor of Ministry program, I had never engaged in any formal study of a therapeutic discipline. Now I would need a general understanding of grief, the grief process, grief recovery, and basic principles of grief counseling.

As I began my research, I discovered that a massive body of literature related to the study and treatment of grief has emerged in the past three decades. Generally speaking, this literature falls into three categories,

A. Academic discourse on the nature of grief and developments in grief counseling and grief therapy.

B. Practical manuals for professional and paraprofessional caregivers to the bereaved or the terminally ill.

C. Writings for grieving persons and the terminally ill themselves.

As I began to familiarize myself with this literature, I also established the following personal goals for this Doctor of Ministry project during the preparatory period.

1. To become familiar and conversant with the developments and trends in the study of grief and its treatment.

2. To become a more competent diagnostician of the various symptoms of grief that may manifest themselves in the lives of my parishioners.

3. To become a more skillful provider of grief care to bereaved persons and their families.

THE CONSULTANTS

Early in the preparatory phase of this Doctor of Ministry project, I began dialoging with two particular clinical personalities, Dr Jeffrey Grace, Clinical Director of the Buffalo Psychiatric Center, and Dr. Lorraine Peeler, Director of the Adult Counseling Center of the Empire State College. My initial conversations with each were regarding the development of an adequate reading list and resource materials for myself related to this project. As both expressed a genuine interest in the project itself, I requested that they serve as my project consultants for the duration of the project. Both consented to serve, as per the terms that each separately deemed appropriate and suitable.

As Project Consultants, Drs. Grace and Peeler would provide guidance in the design, implementation and evaluation of the project. Specifically, they would assist with establishing parameters for the training program, the development of the evaluative instruments to be used (ie., pre and post test questionnaires) the format for each training session, and achieving theoretical clarity and clinical viability for the program. This they did commendably so.

PLANNING

Scheduling was the first consideration in planning.

The number of training sessions to be held, and when, where, and at what time all had to be determined. I took these matters back to the diaconate at its August 1994 meeting for discussion. Two factors mitigated against the feasibility of being able to hold a series of training sessions in the fall quarter of 1994. Firstly, the fall quarter is the busiest quarter of the church calendar year, including such events as: Christian Education Rally Weekend, Men's Day Weekend, the Church Revival, the Church Anniversary, and all of the year end business related to the preparation for the annual church business meeting in January. There simply was no more room available on the church calendar. But secondly, and personally speaking, my wife, Shelia, and I were awaiting the birth of our second child whose due date was October 24, 1994. As it turned out, the doctor's call was near perfect and on October 25, 1994 at 10:20 pm, our son, Samuel Leslie Braxton, was born. Needless to say, the fall of 1994 was ruled out as a scheduling option.

The general consensus of the Diaconate at the August, 1994 meeting was that it was more feasible to hold a series of weekly training sessions sometime between the months of February to April in 1995. It was also at that time that it was decided that Monday nights would be the most suitable for the training sessions because no other meetings were regularly scheduled at the church on Monday nights. It would be preferable that each meeting would begin promptly

at 6:00 pm, be no more than two and a half hours in length, provide a 10-15 minute break in the middle, and end reliably by 8:30 pm.

My next task in planning was to begin meeting with my consultants, Doctor Jeffrey Grace and Doctor Lorraine Peeler, to begin the actual development of the model-in-ministry.

At our first meeting, my consultants and I determined that a minimum of five and possibly six training sessions would be required to accomplish my stated project goals. The following dates for the training sessions were established,

February 6, 1995	6 - 8:30 pm
February 13, 1995	6 - 8:30 pm
February 20, 1995	6 - 8:30 pm
February 27, 1995	6 - 8:30 pm
March 6, 1995	6 - 8:30 pm
March 13, 1995 (if necessary)	6 - 8:30 pm

In our next meeting, my consultants and I turned our attention to the matter of determining exactly what would be the focus of each particular training session and which of the three of us would be best suited to make that presentation. It was agreed that we would all work within our particular academic and vocational strengths: Dr. Grace, a psychiatrist, Dr. Peeler a licensed counselor and an ordained minister in the United Church of Christ, and

myself, a seminary trained ordained Baptist Pastor. Thus, the following topical layout of the training sessions was agreed upon,

Session 1 -	Purpose & Goals of the Training / Foundations of Grief Theory	Pastor Braxton / Dr. Peeler
Session 2 -	Psychiatric Overview- Clinical Aspects	Dr. Grace
Session 3 -	Grief Counseling PI: Tasks of Mourning & Identifying Abnormal Grief Reaction	Dr. Peeler
Session 4 -	Grief Counseling PII: Goals & Principles / Strategies of Intervention	Dr. Peeler
Session 5 -	The Role of Ritual (funerals / Wakes, etc.) & follow up	Pastor Braxton
Session 6 & 7 - (if necessary)	Counseling Role Plays	Dr. Peeler Pastor Braxton

Having established the topics for each of the training sessions, each of the three of us were then given the task of developing a format and a lesson plan for our respective presentations. These lesson plans would be collectively reviewed at our third meeting for purposes of feedback and refinement.

At the third planning session between the consultants and myself, Dr. Peeler raised the proposition of formally compiling a manual for each participant of the grief training. The manual would consist of an outline of each lesson, learning exercises, short readings and other

relevant materials (see appendix #1). The intent was to make the learning truly portable, and provide each participant with a reference tool that he or she could always come back to.

An affirmative answer was quickly reached on the idea of a manual. After all materials to be placed in the manual had been reviewed and refined, Dr. Peeler's office would type them in a common font. The document would then be returned to the church secretary to run off the necessary amount of copies, collate, and place into three ring folders. Forty copies of the training manual would be produced. See pages 86-135 for the full text of the Grief training manual.

The next critical piece of the planning had to do with the development of the evaluative instruments. It was decided that a pre and a post-test should be developed. These questionnaires would include questions representing two distinct categories or subtests, namely knowledge and values. Knowledge questions were related to basic psychiatric, grief and biblical teachings. Value questions related to ideals or principles of our society regarding death and grief. Hence, each of us brought to the fourth meeting, a list of true or false questions that we felt should be included in the pre and post-test questionnaires. These questions were reviewed and discussed by the three of us, in tension with the project goals and objectives. Out

of these discussions, a final list of sixty-one true or false questions was developed (see pages 136-140 for complete text of pre-test questionnaire).

Additionally, five brief short essay questions were also included in the pre and post-test questionnaires.

Though essay questions seek subjective and non-quantifiable data, this data could still provide meaningful indications of the impact of the training upon the participants. Finally, on the matter of the questionnaires, Dr. Grace suggested that the order of the questions be scrambled on the post-test from the pre-test. "By doing so," said Dr. Grace, "we may arrive at a truer response."

A second evaluative instrument was also developed. It was called a Grief Care Training Evaluation Form. In this second instrument, each participant was asked to rate the overall effectiveness of the total training experience, the quality of the training manual, and the efficiency of each individual lesson. See pages 140-141 for the full text of the participant training evaluation form.

THE SUPPORT TEAM

Consistent with the United Theological Seminary's Doctor of Ministry handbook, a support team was organized in my context of ministry to work with me in the execution of the six grief training sessions.

My support team consisted of the chairperson of the

Board of Deacons, Deacon Joe W. Peeples, Sr.; the chairperson of the Board of Deaconess, Deaconess Marcia Mayes; a member of the Audio / Video ministry, Sister Sarah Kimble; vice chairman of the Deacon Board, Deacon Pleasant Thomas; and an usher and deacon-in-training, brother Ted Cook, Sr.

Each of these five persons served a very key function toward a smooth execution of the training sessions. The two chairpersons, Deacon Peeples and Deaconess Mayes, were responsible for notifying the members of their respective boards regarding dates and times of the training sessions and generally lobbying these very busy Christian men and women to insure that attendance did not drop off at any time in the six weeks of training. The vice-chairman, Deacon Thomas, was responsible to coordinate the devotional period that would kick-off each training session. Our Audio/Video representative, Sister Kimble, was present to record and videotape all training sessions. Brother Ted Cook, Sr. was our resident mister everything, keeping up with the attendance sheets, making certain that easels and flip charts were present in the room, pens and markers available for both presenters and participants, and that presenters had coffee or water at their disposal during their presentations.

The church Sexton, Brother Dennis King, was an unofficial, but extremely vital, support person. Each week,

prior to start of the training sessions, Brother King would make certain that the church Parlor was clean and properly set up, with coffee, tea, water, and light refreshments laid out for the presenters and the participants as they entered the room. Following each week's session, Brother King cleaned up and restored the Parlor to its normal order.

FORMAT

The training sessions took on a specific format. Exempting the first and the last sessions, when time had to be allotted for administering the pre and post test questionnaires respectively, the time was generally utilized in the following manner,

5:30 pm **REFRESHMENTS AND FELLOWSHIP**
Early arrivers unwound with some refreshments and light hearted fellowship while waiting for others to arrive and the evening's session to begin.

6:00 pm **DEVOTION**
Under the leadership of Deacon Pleasant Thomas, fifteen minutes of song, scripture and prayer warmed up the house for the start of the night's presentation.

6:15 pm **PART I OF PRESENTATION**

7:15 pm **BREAK**

7:30 pm **PART II OF PRESENTATION**

8:15 pm **WRAP-UP & PRAYER**

8:30 pm **DISMISSAL**

CHAPTER FIVE

THE FINDINGS

This chapter reports the findings derived from an analysis of the data obtained through the administering of the pre and post tests and examination of the attendance records for this project.

ATTENDANCE PATTERNS

Six training sessions on grief and how to minister to grieving persons were held at First Shiloh Baptist Church of Buffalo, New York between the months of February and March, 1995. The focal group for this training was the Diaconate: the Board of Deacons and the Board of Deaconess. However, participation was extended to any parishioner interested in (or simply curious about) ministering to the grieving.

At the time of the training sessions, there were thirty-two active (exempting "emeritus" officers) members of the diaconate - eighteen deacons, and fourteen deaconess. Twenty, or 62.5%, of the diaconate membership participated in the training sessions. Additionally, ten members at large from the congregation participated in the training. In total, there were thirty participants in the training sessions. However, twenty-four of the participants attended

the required amount of at least five sessions to successfully complete the training and were included in the pre and post-training analysis.

TABLE 1

GENDER BREAKDOWN OF PARTICIPANTS IN TRAINING SESSIONS

Total # of Partici.	% Male	% Female	% of Participating Diaconate Members Male	% of Participation Diaconate Members Female	% of Non-Diaconate Members Male	% of Non-Diaconate Members Female
30	40.0 (12)	60.0 (18)	45.0 (9)	55.0 (11)	30.0 (3)	70.0 (7)

Table #1 provides a breakdown of the training sessions participation by gender, both in terms of Diaconate presence and non-diaconate presence. Forty-five percent of the diaconate participation (9 of 20) was male. Even though fifty-six percent of the diaconate membership (18 of 32) is male. Male presence drops even more among the non-diaconate participation, with only thirty percent (3 of 10) male participation, as opposed to seventy percent (7 of 10) female participation.

TABLE 2

TRAINING SESSION ATTENDANCE BREAKDOWN

Session	Number in Attendance (not including presenters)	% Diaconate	% Non-Diaconate
#1 February 6th	19	73.68 (14)	26.32 (5)
#2 February 13th	23	69.6 (16)	30.4 (7)
# 3 February 20th	24	70.8 (17)	29.2 (7)
#4 February 27th	21	61.9 (13)	38.1 (8)
#5 March 6th	25	68.0 (17)	32.0 (8)
#6 March 13th	25	68.0 (17)	32.0 (8)

Table 2 provides the numerical breakdown of the attendance patterns of the training session participants. It also gives a numerical breakdown of participation based upon diaconate or non-diaconate status. The attendance was at its lowest at the first training session with only eighteen persons present. Each of the nineteen persons present for the initial training session were administered a pre-test questionnaire. Eighteen of those nineteen persons would go on to attend the required five sessions. At the beginning of session two, an additional seven participants who were not present the week prior were administered a pre-test questionnaire in a separate room. Six of the seven new participants on week two would go on to attend the required five sessions. This would account for the total of twenty-

four participants who successfully completed the training, ie., attended at least five training sessions and completed both pre-test questionnaires.

TABLE 3

FREQUENCY OF TRAINING SESSION ATTENDANCE

Number of Sessions Attended by Participants	Number of Participants	% of Total Participants
1 Session	0	0.0
2 Sessions	3	10.0
3 Sessions	2	6.67
4 Sessions	2	6.67
5 Sessions	13	43.34
6 Sessions	11	36.67

30 Participants - total attendance of persons participating in training sessions

Table 3 provides additional description of the attendance patterns exhibited during the six training sessions. This table displays the number of training sessions that participants were able to attend. One hundred percent of the participants attended at least two sessions. However, the total number of participants who attended four sessions or less was only seven. An extraordinary forty-three percent (13) of the participants attended five sessions. And an equally extraordinary thirty-six percent (11) of the participants attended all six sessions. Over eighty percent

of the participants (24 of 30) attended either five or six sessions! These twenty-four completed both pre and post-test questionnaires. The stability of the attendance patterns should have contributed to the impact of the training sessions upon the participants.

TRAINING SESSION EFFECTIVENESS

The twenty-four participants who successfully completed the grief training, that is, attending at least five of the six sessions and completing both pre and post-training questionnaires, also were administered a Grief training evaluation form. This instrument was designed to measure the participants level of satisfaction with the training experience overall, the effectiveness of each individual session and its presenter(s), and the quality of the training manual that was developed and distributed. See pages 143-144 for full text of the evaluation form.

Table eight shows that almost seventy-one percent of the participants rated the overall training experience as being "very helpful" in preparing them to better minister to grieving persons. The remaining twenty-nine percent of the participants rated the training as having been "helpful."

TABLE 8

HOW DO YOU RATE THE OVERALL EFFECTIVENESS OF THE TRAINING SESSION IN PREPARING YOU TO BETTER MINISTER TO THE GRIEVING?

	Very Helpful	Helpful	Not Very Helpful	Not Helpful At All
Number of Participants	17 (70.83%)	7 (29.17%)	0%	0%

Table nine demonstrates both the participants impressions of the quality of the coordination of the training and the quality of the training manual which was distributed to them and utilized as the primary training tool.

TABLE 9

	Excellent	Good	Fair	Not Good	Poor
How well coordinated was training?	14 (58.34 %)	10 (41.67%)	0 (0%)	0 (0%)	0 (0%)
Quality of the training manual	20 (83.34%)	2 (8.3%)	2(8.3%)	0 (0%)	0 (0%)

Table ten records the participants impressions of the effectiveness of each **individual** training session.

TABLE 10

	Very helpful		Helpful		Not very helpful		Not helpful at all	
Session	#	%	#	%	#	%	#	%
1	15	(62.5%)	10	(41.7%)	0	(0%)	0	(0%)
2	17	(70.8%)	17	(70.8%)	0	(0%)	0	(0%)
3	20	(83.3%)	4	(16.7%)	0	(0%)	0	(0%)
4	10	(83.3%)	5	(16.7%)	0	(0%)	0	(0%)
5	18	(75.0%)	6	(25.8%)	0	(0%)	0	(0%)
6	17	(70.8%)	7	(29.2%)	0	(0%)	0	(0%)

Ratings on the effectiveness of individual sessions were consistently high. All ratings were either that of "very helpful" or at least, "helpful." The two sessions that were instructed solely by Dr. Lorraine Peeler (sessions 3 and 4) received the highest ratings from the participants with 83.3% of the participants rating both as "very helpful." The lowest ratings were given for sessions number one. Perhaps, in part a response to the logistical clumsiness of getting things started. By the second week, the mechanics of the sessions were smoothing out and the participants and presenters comfort level raised accordingly.

IMPACT ON KNOWLEDGE, VALUES AND STRATEGY

One of the objectives of this model-in-ministry project was to demonstrate the training's ability to produce measurable growth in the participants knowledge of grief and their understanding of how to care for the grieving. As stated in chapter four, a pre-test and post-test questionnaire was developed collaboratively by Dr. Grace, Dr. Peeler and myself, to be used as the project's primary evaluative tool. The pre-test questionnaire was administered at the beginning of the first and second training sessions. The post-test questionnaire was administered at the close of the sixth and final session. Additionally, a participant evaluation of the training was also developed and administered after the conclusion of the

training.

The pre and post-test questionnaires (see pages 130-139) were divided into two parts. Part one consisted of sixty-one true or false questions. Part two consisted of five essay questions. Twenty-six of the questions in part one are designed to measure the participants knowledge about grief, and the grief process, and related matters. Collectively, we refer to these questions as the "knowledge subtest." The remaining thirty-five of the questions in part one are designed to measure value or attitude of the participants. These questions collectively are referred to as the "value subtest."

At the end of each questionnaire there were a series of five brief essay-type questions. Two of the questions could be considered value in nature. Question #3 was: "If a ten year old child who has just lost their father asked you, "Deacon, why did God take my daddy away?" How do you respond?" Question #4 was: "An obviously gay man asks you to ask the pastor if he will perform the funeral for his deceased lover who died of AIDS. In your opinion, should the pastor perform this funeral?" The other three questions were more knowledge related.

GRIEF CARE QUESTIONS PART I

Twenty-four of the thirty participants in the grief care training sessions completed both the pre-test and the

post-test. Findings from the pre and post-test questionnaires are included in tables 4-7. See pages 148-158. An "ideal" response for each true or false question was developed by consensus agreement among Dr. Grace, Dr. Peeler, and myself. As shown in table 4, eleven of the twenty-four participants had a higher overall total score (answered more questions with the ideal response) on the post-test than on the pre-test. Three of the twenty-four participant's scores remained unchanged. Ten of the twenty-four participants scored higher on the pre-test than on the post-test. The total scores reflect the sum of all questions, both value and knowledge combined.

TABLE 4

DIFFERENCE BETWEEN PRE AND POST-TOTAL SCORES

Total Score	No. of Participants	% of Participants
-11	1	4.2
-4	1	4.2
-3	3	12.5
-2	2	12.5
-1	2	12.5
0	3	12.5
+2	1	4.2
+3	3	12.5
+4	3	12.5
+5	1	4.2
+6	2	8.3
+9	1	4.2
TOTAL	24	100.0

NOTE: Total score equals the post-test score minus the pre-test score. Therefore, a positive score means that the post-test was higher than the pre-test score. A zero means the same score was received on both tests. A negative score means the post-test score was lower than the pre-test score.

On Table five, below, 8 of the 26 (30%) Knowledge and 9 of the 35 (26%) Value questions had a significant number of participants who responded with the not ideal response on the pre-test but did answer with the ideal response on the post-test. This would indicate a possible positive effect of the training for these questions. On the majority of questions on both subtests there was virtually no significant change on responses for both pre and post-test, 16 of 26 (61%) Knowledge questions and 17 of 35 (49%) Value questions.[1] Remarkably a negative effect of the training could be interpreted from the Value questions where on 9 of 35 questions a significant number of participants responded with the ideal response on the pre-test and changed to the not ideal on the post-test.

TABLE 5

COMPARISON OF PRE NOT IDEAL / POST IDEAL RESPONSES TO PRE IDEAL / POST NOT IDEAL

	*Pre Not Ideal Post Ideal	**Pre Ideal / Post Not Ideal	No Change
Knowledge Questions	8 of 26 Question	2 of 26 Questions	16 of 26 Questions
Value Questions	8 of 35 Questions	9 of 35 Questions	18 of 35 Questions

* At least 3 (12.5%) more participants had ideal responses on the individual post-test as compared to pre-test questions. See columns 6 & 7 on tables 1 and 2.

** At least 3 (12.5%) more participants had ideal responses on the pre-test questions as compared to post-test.

[1]It was the opinion of Dr. Grace that the standard of 12.5% or more would be accepted as "significant" occurrence within the context of this project.

On table 6 (see pages 150-153) the knowledge subtest, 14 of 26 (54%) questions showed what might be interpreted as a positive response to the training, at least 3 participants who had not ideal responses on the pretest answered in the ideal fashion on the post-test (column #4). Ten of 14 questions were psychiatric or counseling in nature (numbers: 1, 3, 6, 7, 8, 9, 10, 43, 44, 54), the remaining 4 were religious questions (numbers: 19, 28, 33, 60). Question number 4 of the knowledge subtest was very remarkable as only 6 participants responded with the ideal answer on the post-test as compared to 15 on the pre-test. Note that 10 participants had answered with the "ideal" response on the pretest and changed to the not ideal response on the post-test. This question related to universally making a recommendation to see a psychotherapist or a counselor.

On Table 7, (see 154-158), the value subtest, 16 of 35 (40%) questions showed a positive response to the training with at least 3 participants (12.5%) who had not ideal responses on the pretest answering in the ideal fashion on the post-test (column #2). On questions 18, 55, and 59, the impact of the training was more dramatic with 9, 10, and 14 participants changing their pre-test not ideal response to ideal on the post-test. It is important to note also that on 11 (31%) of the value questions (number: 13, 14, 29, 31, 36, 42, 46, 47, 50, 55, 59), a possible negative effect was noticed where at least 3 participants changed

their pretest ideal responses to not ideal on the post test (column #3). It appears that the impact of the training upon value and attitude of the participants is not easily measured by this questionnaire format. Perhaps largely due to the very ambiguous nature of value and attitude questions, responses invariably will appear more random than those of knowledge questions.

GRIEF TRAINING QUESTIONNAIRE PART II

The second part of the questionnaire consisted of five subjective questions that were designed to investigate the participants practical application of learnings as well as provide additional measurement for shifts in attitude regarding certain social circumstances that may accompany an occasion of death. No consensus ideal answer for these questions were developed between my consultants and myself. However, notable shifts in attitude or application of learning could be viewed as indicative of positive impact of the training on the individual. The questions were as follows,

1. If a terminally ill member of the church quoted James 5: 14-15 and asked you to lay hands on them and "pray the prayer of faith" over them to heal them, what would you do?

2. A recently widowed woman comes to you and says "Deacon, I know I should be strong, but I just can't stop crying when I think about him!" What would you say to her?

3. If a ten year old child who has just lost their father asked you, "Deacon, why did God take my daddy away?" How do you respond?

4. A gay man asks you as a deacon to ask the Pastor if he will perform the funeral for his deceased lover who died of AIDS. In your opinion, should the Pastor perform the funeral?

5. How would you prepare yourself to visit a church member who has recently experienced the death of a loved one?

With the exception of questions #3 and #4, all others were answered almost identically on the post-test as they had been on the pre-test by the participants. Generally speaking, the participant's responses to questions 1, 2, 3, and 5, were very sound or at least adequate from a theological (#1), methodological (#5), or a clinical perspective (#2). On question #3, six participants became more open about their feelings and knowledge in addressing the issue of a child's question about the loss of a parent. For example, one participant on the pre-test wrote "only God knows the answer... then explained about a seed planted must die in order to live!!!" One the post-test, he would simply answer, "I don't know."

However, question number 4 did produce some noteworthy apparent shifts in attitude between pre-test and post-test,

> A gay man asks you to ask the Pastor if he will perform the funeral for his deceased lover who died of AIDS. In your opinion, should the Pastor perform this funeral?

Participant #2, (a Deacon)

Pre-test response:
"I would leave this to the Pastor to decide."

Post-test response:
"Yes!"

Participant #7, (a non-member of the Diaconate)
Pre-test response:
"It's up to the Deacons, Pastor and Church polity in such matters."

Post-test response:
"**Yes!** The Pastor should not be concerned about the life style of the departed."

Participant #13, (a Deaconess)
Pre-test response:
"I don't know."

Post-test response:
"**Yes**, if the family will conduct themselves properly."

Participant #15, (a Deacon)
Pre-test response:
"I'm not sure!! I have mixed feelings and opinions about this."

Post-test response:
"**Yes!**"

Obviously, the social circumstances surrounding the occasion of death in question #4 touched off significant apprehensiveness and discomfort among certain participants at the outset of the training sessions. Apparently, the training impacted these participants thinking regarding the church's role in providing grief care in socially questionable circumstances. These four participants represent (16.67%) of the total participants.

CONCLUSION

Our general conclusion is that the training had a positive impact on the participants response to specific knowledge questions with 54% of the questions moving to the ideal response on the post-test. For value questions, the

impact of the training was not clearly measured by part I of the pre and post-training questionnaires. However, when examining part II of the questionnaires - the short essay questions - certain individuals did articulate a demonstrative shift in attitude as a result of this training experience.

CHAPTER SIX

SUMMARY & CONCLUSIONS

We are strong in part. But we are weak in part as well. At once, we're both...

Dr. William Mayes
Deacon, First Shiloh Baptist Church
Buffalo, New York

The above comment of Dr. William Mayes, is certainly applicable to the work of developing, implementing, and documenting this model-in-ministry project.

The project had both strengths and weaknesses. This sixth, and final, Chapter will highlight some of both for purposes of critical reflection upon this particular project and for the benefit of others who might attempt similar projects in the future.

STRENGTHS

A key strength of this project was the high level of commitment that the participants themselves brought to it as evidenced by the extraordinary attendance patterns. The winter of 1995 was very cold and bitter in Buffalo, New York. And February recorded the coldest temperatures of any month in the year. Many of the participants in the training were senior citizens who suffer various degrees of physical

hardship brought on by cold and wet weather. Yet, "eighty percent" of the participants attended either five or all six of the training sessions. Under these circumstances this was a significant achievement. It reflects in part how serious the men and women of the First Shiloh Baptist church Diaconate are about the ministry to which they have been called.

However, I also believe that the extraordinary attendance patterns demonstrate the **power of a Covenant** among the regenerated people of God. The participants in this project did not have to come. They were compelled to come because they had committed themselves to do so. This was particularly evident in the attendance at the sixth and final session which was originally scheduled on an "if necessary" basis. Only at the close of the fifth session was it "suggested" to the participants that we meet one more week for additional role play activity. Without hesitation, the response was "we gave our word to do whatever it takes to make the project a success!" The covenant made at the outset of the project translated in stability throughout its duration. An unexpected lesson learned from this project has been that more open and honest dialogue leading to a covenant act between Pastor and people needs to undergird the pursuit of the goals and objectives of ministry.

That the training sessions were relevant to the duties and responsibilities of the focal group, the diaconate, cannot be disregarded in its possible impact upon the project's success. Each member of the First Shiloh Board of Deacons is assigned to a certain number of families within the congregation. This arrangement is referred to as our "Family Ministry." When a family in the congregation experiences a critical illness, or a death they contact their assigned deacon who in turn, will go and visit with them and assist them in whatever way that they can. It is primarily in the context of this family ministry that the members of the diaconate are called on to minister to grieving individuals and families. Thus, this grief training spoke directly to one of the fundamental expectations and challenges of the diaconate office. Which, in all probability, increased the diaconate members willingness to participate. These sessions provided relevant training for the diaconate ministry. As one deacon commented, "If it'll make our job easier, I'm all for it."

Closely related to the importance of relevance was that of comraderee. The focal group (diaconate) was already a cohesive outfit with a group identity and a team spirit. There was a built-in system of accountability that could not have existed to the same degree if the project had

involved only individuals who had no collective function or group identity beyond training itself. Each week, participants came looking for each other to be there. Presenters only had to concern themselves with preparing their presentation.

Another strength of this grief training model was the training manual that was developed and utilized. The intent behind the development of the manual was to provide the participants with a resource tool and reference material that they could always come back to. As reflected in table number nine, 20 of 24 participants (or 83.3%) gave a rating of "excellent" for the quality of the training manual. One participant wrote on the post-training evaluation form, "with this booklet, now I'm grounded!"

The manual made it easy for all participants to follow along the outline of each presenter during each weeks presentation. With lecture outlines, exercises, readings, and homework, all included in a single package, the handbook itself is potentially empowering.

The greatest strength of the project was the overall effectiveness of the training sessions.

As indicated in table eight, over seventy percent of the participants stated on their post-training evaluation form that the training was very helpful. Consider some of the accompanying comments that participants wrote,

"Now I realize that some of my comments to grieving people in the past may have actually made them feel worse."

"The training has made me more sensitive to the grieving. I don't have all the answers, but I can be there with them."

"It's the process [grief process] that I understand now. Now I'm ready for service!!"

"The most critical learning for me was that I must work through my own feelings about grief before I can assist others."

"I didn't know before that there was a difference between grief and depression."

"There were myths and misinformation that was clarified for me!"

"Prior to this training, grief and I didn't get along! Now I have a framework to approach the grieving."

"I've always wanted to come alongside people during times of loss, but didn't know what to say or do. Now I'm comfortable attempting to be of help to someone in the hour of loss."

Clearly, some participants felt very helped by the training experience.

Empirical data suggests that the training had a clear positive impact on the participants response to specific knowledge questions with 54% of the questions moving to the ideal response on the post-test. Special attention was given to question number #4, where remarkably only 6 participants responded with the ideal answer on the post-test as compared to fifteen on the pre-test. Ten of the participants had answered with the ideal response on the pre-test and changed to the not ideal response on the post-test. This shift may not be as problematic as it at first appears. The question reads,

A recommendation to see a psychotherapist or a counselor is always appropriate.

The ideal answer is "true." We hypothesize that the general impact of the training served to do two things relevant to this question: 1) raise the participants level of confidence in their ability to adequately minister to grieving persons, and 2) serve to redefine grief as the "natural" response to loss. Thus, the training decreased their likelihood of recommending the bereaved to seek professional help if no symptoms of an abnormal or complicated grief reaction have been observed. If this is the case, then what would become necessary in future training is greater clarity on a matter of caution: That for sake of newly gained confidence or newly acquired knowledge, those who minister to the bereaved should not neglect to maintain the proper professional support for themselves or for those they minister to.

For value questions the impact of the training was less clear, with 40% of the questions moving to the ideal response on the post-test and 31% of the questions moving from ideal response to **not** ideal on the post-test. However, the shift of 4 participants toward a more tolerant response on the fourth essay question strengthens our belief that attitude and value were in fact significantly impacted by the training. Our goals were to move people emotionally and on their values as well as to increase their knowledge base. In the opinion of both of my consultants, it is far more

difficult to affect a change in attitude or value than in knowledge. The changes in response to short essay question number four, may suggest that the training affected them to "relax" their apprehensiveness about the church's involvement in circumstances that are socially or morally questionable. This is a significant accomplishment.

Our project goals included enhancing the quality of the diaconate's grief care to individuals and families throughout the congregation. In the months since the completion of this project. I have observed subtle to dramatic changes in the actual manner of care given by some members of the First Shiloh diaconate. Recently, in a diaconate meeting, during the report of the bereavement committee, a deacon was asked about the progress of a recently widowed member of our congregation. The deacon replied,

> Fine, I went by and sat with her again and we got to talking about him [her deceased husband] and, she had a **really good cry**... she's getting it out! So she's coming along.[1]

This same deacon, prior to our training sessions typically interpreted strong grief reactions such as hard crying, as "not taking it well," and would advise the bereaved to "just be strong." She has grown in her understanding of the necessity for the bereaved to experience the pain of their loss so that they can move on.

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[1]Eleanor Mason, at December 18, 1995, First Shiloh Baptist Church, Board of Deacons Meeting, Buffalo, NY.

According to her, the training has made her more diagnostically astute.

Another deacon, who previously showed a tendency to attempt to "say something that will help," when ministering to the bereaved, has shown on a couple of recent occasions of ministering to grieving families a willingness to just sit quietly and speak only if necessary or appropriate. He appears to have internalized from the training that its okay not to say anything - just be there. The training may have enabled him to better grasp the notion of authentic "ministry of presence." When I brought it to the attention of this particular deacon that I had noticed a change in his handling of grieving families, he surprised me by quickly quoting from memory an old saying that I had shared in the training sessions,

> A wise man speaks because he has something to say,
> A fool speaks because he feels he has to say something.

On another occasion, a deaconess brought it to my attention that a recently widowed member had not so much as shed a tear in her presence (they were best friends) since the loss of her husband. I made a pastoral call to see this member. After a series of events, a professional referral was in fact made because of the disclosure of several traumatic issues that were complicating her ability to grieve. That counseling is still ongoing and the member appears to be making progress.

Overall, the training experience has produced several

signs that diaconate members and others who participated, generally have a clearer understanding of the grief process and how it works, are more intentional in their strategies of intervention, and are more comfortable and more willing to minister to grieving persons.

WEAKNESSES

The biggest weakness of the project was having to hold the training sessions in the evening (6-8:30 pm). While this was the most convenient time from a scheduling stand point, it did not prove to be the most expedient time from a physical and mental standpoint. Coming at the end of long busy work days, many of the participants and presenters were demonstratively fatigued during the training sessions. Often, many of the participants had come directly from work without having had an opportunity to eat dinner. These factors at points may have compromised the attention span and the comprehension of the participants. However, all sessions were videotaped, and made available to participants who either missed a session or simply were not able to pay very close attention at a particular session for whatever reasons. Participants who needed to review a session simply had to call the church and request that the Sexton, Bro. Dennis King, set up the desired tape, television and VCR in the church parlor for their review at an appointed time during regular business hours or arranged evening hours.

It is the consensus opinion of my consultants and myself that the training might have had more impact at points if more interactive exercises had been done in small groups as opposed to all activities remaining in a single large group context. This would have allowed each participant to have a more personal involvement in the training which in turn may have increased the impact of the training upon them. As single large group format was utilized throughout the sessions only because it was the thinking of my consultants and myself at the outset of the project that for eventual purposes of evaluation, we wanted to make certain that all participants had the same experience. In hindsight, we believe that the participant's evaluation form should have included questions that spoke directly to format issues, thus providing a more concrete basis of evaluation on this point.

It is also felt that refinement of the evaluative instruments might be in order for future projects. Firstly, in the essay section of the pre and post-test questionnaire we would include more specific knowledge based questions. These questions might include,

> List and explain the stages of grief for the terminally ill according to Kubler-Ross.
>
> According to Wimberley, what are the stages of the grief process for the bereaved?
>
> What is the difference between grief counseling and grief therapy?

List the 10 universal principles of grief counseling.

When is mourning completed?

Questions such as these would certainly have provided a much clearer picture of the actual learnings of the participants in the project.

Secondly, hindsight again suggests that other evaluative instruments should have been used in addition to the pre and post-test questionnaires, and the participant training evaluation form. Such as a weekly evaluation form designed to get the participants feedback on the effectiveness of each particular session while the experience was still fresh in their minds. This information would have been tremendously helpful to the overall evaluation of the project. Additionally, hingsight suggests that Luvert scale question format would have been advantageous for pre and post training questionnaires.

RECOMMENDATIONS

A follow-up ministry needs to be implemented to address the long term grief care needs of the bereaved. This project,and the preparation for it, has impressed upon myself and the persons who participated in it that grief care ministry only **begins** at the time of death. Thus, the short term after care that the deacon's ministry provides leaves a great void for persons whose season of grief endures significantly for up to a couple of years after the

loss. As a church with a ministry of love it is not our desire to leave grieving members to wander through this season alone. A long term ministry needs to be set in place.This ministry should take the form of a support group designed for bereaved persons who are at least two months removed from their loss. A weekly or bi-weekly meeting format could be established with the objective of guiding bereaved persons through the completion of the tasks of mourning. Generally speaking, a one year involvement in the grief support group would accomplish this objective. This would make the grief ministry of the church comprehensive, in that, the diaconate would continue to be trained and entrusted to provide anticipatory and immediate after care grief ministry (up to 10 weeks after death), and then link with the grief support group that would follow bereaved persons through to resolution. Professional support would be needed to sustain the therapeutic integrity of a grief support group. This type of ministry is currently being developed for First Shiloh Baptist Church.

Finally, in any future project of this nature, a concerted effort needs to be made to recruit and involve more men. Our attendance demonstrated that both within and without of the diaconate, women were more likely to avail themselves to a ministry of this nature. This does not have to be and should not be. It may be true that our society nurtures women to be better nurturers than men. However,

men grieve too. And grieving men would benefit greatly from having the strong and gentle touch of another man who is equipped to help him through his hurt. Carolyn Osiek offers this insight on the Galatians passage that we use in our Biblical foundations chapter,

> ...Paul may be doing something quite radical here: he is holding up traditionally feminine values [serving one another] as ideals for everyone, male and female, and perhaps especially for the Christian men who are his principal addressees.[2]

PERSONAL GROWTH

I began this project with an admission that I was deficient in my familiarity with therapeutic literature and practices. The needs of my pastoral context pressed me to address this matter. In essence, this project was an attempt at an authentic pastoral response to a clear and prevalent need within this ministry.

My personal goals of becoming familiar with the discourse and the developments in grief care, of becoming a more astute diagnostician of grief symptoms, and a better provider of grief care have all been achieved. By no means is this to suggest that I have achieved expertise in these matters. I am actively pressing toward that (expertise) mark. However, I am confident that I have achieved proficiency and strength in matters of grief care. This is

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[2]Carolyn Osiek, "Galatians," The Women's Bible Commentary, Carol A. Newman and Sharon H. Ringe, Eds., (Louisville: Westminster John Knox Press, 1992) 337.

the vocational enrichment, and the collegial interaction with peers from across the country have all been invaluable experiences that I do believe have had revitalizing impact upon my ministry and my life in general. I have learned the value of continuing to learn if one is to continue to lead.

"New occasions teach new duties,
time renders ancient good uncouth,
they must ever onward be,
those in pursuit of truth."
Harry Emerson Fosdick

APPENDIXES

GRIEF INTERVENTION TRAINING PROGRAM

TRAINING MANUAL

FIRST SHILOH BAPTIST CHURCH

INSTRUCTORS
Dr. Jeffery M. Grace
Dr. Lorraine E. Peeler
Rev. Leslie M. Braxton

GRIEF INTERVENTION TRAINING PROGRAM
OUTLINE

PART I - INTRODUCTION

A. PURPOSE AND GOALS OF THE TRAINING

B. PRESENTATION OF THE INSTRUCTORS

PART II - FOUNDATIONS OF GRIEF THEORY

A. THEORY
- ATTACHMENT/LOSS
- MOURNING/BEREAVEMENT

B. WHAT IS GRIEF?
- NORMAL/COMPLICATED GRIEF (DEPRESSION VS. GRIEF)
- CULTURAL AND BIBLICAL CONSIDERATIONS

PART III. PSYCHIATRIC OVERVIEW - CLINICAL ASPECTS

A. DSM-IV
- ROLE
- DIAGNOSIS

B. GRIEF REACTION

C. DEPRESSION & ADJUSTMENT DISORDER

D. PSYCHOTIC DISORDER

E. CASE EXAMPLES

F. GLOSSARY OF TERMS

PART IV. GRIEF COUNSELING

A. GRIEF COUNSELING VS. GRIEF THERAPY

B. GOALS OF GRIEF COUNSELING

C. WHO DOES GRIEF COUNSELING

D. WHO RECEIVES GRIEF COUNSELING

F. PRINCIPLES AND PROCEDURES

G. IDENTIFYING ABNORMAL GRIEF REACTIONS

H. SPECIAL TYPES OF LOSSES

I. FAMILY COUNSELING ISSUES

PART V. INTERVENTIONS

A. RITUAL - FUNERAL/WAKE ETC.

B. LEGAL ISSUES

C. AFTER CARE - ASSESSMENT & BIBLICAL SUPPORTIVE COUNSELING

- DIACONATE FOLLOW-UP
- SUPPORT GROUPS
- WHEN TO REFER FOR ADDITIONAL HELP

PART I - INTRODUCTION TO GRIEF COUNSELING TRAINING
REV. LESLIE BRAXTON, INSTRUCTOR

I. Purpose and Goals of the Training

A. Purposes -

General

- To increase the diaconate familiarity with the developments and trends in the area grief in order to better assist the needs of the members in particular in the church.

Biblical

- To more effectively "Bear one another's burdens and so fulfill the law of Christ." Galatians 6:2

B. Goals

- To develop a shared ministry of grief intervention between the Pastoral staff and lay diaconate.

- To enhance the competence of Deacons to provide quality grief intervention to individuals and families throughout the congregation.

- To provide grieving persons in the congregation with more immediate, personalized, and thorough support from their church in their time of loss and sorrow.

II. Presentation of Instructors

- Jeffery M. Grace, M.D.
  Clinical Director - Buffalo Psychiatric Center
  Clinical Assistant - Professor of Psychiatry - SUNY at Buffalo

- Lorraine E. Peeler, Ph.D.
  Counselor - SUNY- Empire State College
  Coordinator - Liberty Partnership Program - SUNY at Buffalo
  President - Prominent in Christ Ministries

- Rev. Leslie D. Braxton, M.Div.
  Pastor - First Shiloh Baptist Church

PART II
FOUNDATIONS OF GRIEF THEORY
Dr. Lorraine Peeler, Instructor

I. THE BASIS OF GRIEF IS ATTACHMENT.

Attachment is:

- the tendency in humans to make strong affectional bonds with others: these bonds—
  - come from a need for security and safety;
  - develop early in life;
  - are usually directed toward a few specific individuals;
  - tend to endure throughout a large part of life.

ACTIVITY ONE

Name three family bonds/attachments.

1. _____ 2. _____ 3. _____

Name three non-family bonds/attachments.

1. _____ 2. _____ 3. _____

II. NATURE OF GRIEF

GRIEF IS:	- a strong "emotional reaction";
	- an outward or emotional expression;
	TO LOSS OF AN ATTACHMENT OR BOND.

LOSS IS...
WHEN ATTACHMENT BONDS ARE THREATENED OR BROKEN.

B. Grief is

- a departure from the state of health and well-being;
- is psychologically trauma;
- implies a need for psychological healing to bring the mind back into homeostatic balance - equilibrium;

ACTIVITY TWO

Name three emotional reactions to loss.

1. _____ 2. _____ 3. _____

Name three biblical examples of emotional reactions to loss.

1. _____
2. _____
3. _____

III. MOURNING

A. When a person experiences a loss there is an imbalance in their life. A sense of balance needs to be restablished. Mourning is the process that helps us to regain our sense of balance after a loss.

Mourning is.....
an adaptation to or becoming accustomed to a loss.

B. Because mourning is a process – there are tasks that need to be accomplished.

Task 1 - Accept the reality of the loss.

Task 2 - Experience the pain of grief.

Task 3 - Adjust to an environment in which the deceased is missing.

Task 4 - Withdraw emotional energy and reinvest in another relationship.

C. Mourning is over when:

(1) the "tasks" of mourning are completed;
(2) the person can think of the deceased without pain:
Note: sadness and pain are different

D. Some biblical examples of mourning/grief –

(1) David - II Samuel 12:16-23
(2) Rizpah - II Samuel 21: 8-14

ACTIVITY THREE

1. Identify the bonds/attachments in the above passages.

2. Identify some expressions of grief and tasks of mourning.

3. Are these reactions normal?

IV. Normal/Uncomplicated Grief Reactions/Uncomplicated Mourning

A. There are a broad range of feelings and behaviors that are common after a loss. There are four general categories:

FEELINGS

- sadness
- anger
- guilt/self-reproach
- anxiety
- loneliness
- fatigue
- hopelessness
- shock
- yearning
- emancipation
- relief
- numbness

PHYSICAL SENSATIONS — (most commonly reported)

- hollowness in stomach
- tightness in chest
- tightness in throat
- oversensitivity to noise
- a sense of depersonalization
- breathlessness, feeling short of breath
- lack of energy
- dry mouth

COGNITIONS - different thought patterns often short-lived but can lead to depression or anxiety.

- disbelief
- sense of presence
- hallucinations
- confusion
- preoccupation

BEHAVIORS - specifically associated with normal grief reactions

- sleep disturbances
- absent-minded behavior
- dreams of the deceased
- sighing
- crying
- appetite disturbances
- social withdrawal
- searching and calling out
- restless overactivity
- visiting places or carrying
  - avoiding reminders of the deceased
  - objects that remind the survivor of the deceased
  - treasuring objects that belonged to the deceased

B. Differences between grief and depression

- They manifest similar characteristics – sleep disturbances, appetitite disturbances, instense sadness – but depression includes an intense loss of self-esteem – grief does not.

C. Determinants of Grief

The level of grief a person experiences is often predicted by:

1. Who the person was
2. Nature of the Attachment
   - strength of the attachment:
   - security of the attachment

- ambivalence in the relationship

3. Mode of death - circumstances around the death - i.e., violent vs. natural causes;
4. Historical antecedents - how the person grieves previous losses
5. Personality variables - age, sex, emotional vs. unemotional, coping skills;
6. Social variables - culture/ethnicity, religion, social support

---

ACTIVITY FOUR

Answer the following objective questions.

1. The term "homegoing" as it relates to the funeral of a loved one - comes from the African-American tradition. _____ True _____ False

2. African-Americans are more emotional when they lose a loved one than European-Americans? _____ True _____ False

3. Most African-Americans want some type of religious ceremony in the face of the loss of a loved one, despite their religious commitment?
_____ True _____ False

4. Most African-Americans frown upon cremation? _____ True _____ False

5. African-Americans, while in slavery, still had their own funeral ceremonies which included rituals from the African traditions, after the funerals allowed by whites. _____ True _____ False

6. There is a higher probability that an African-American family will lose a loved one by violent death than a European-American family?
_____ True _____ False

ACTIVITY FIVE

CASE STUDY

Sis. Mary Brown is a single mother of 35 years old. She is a faithful choir member. She has recently learned that her 16 year old son Shawn was killed in a spray of bullets from a drive by shooting. She refuses to go to the hospital to view her sons body and does not want to even talk about her son. Other relatives have confirmed that it is her son. But she still refuses to discuss the situation. Her family and friends seem to be distressed because they can't get her to respond to the situation.

Discussion Questions

1. Is it necessary for Sis. Brown to mourn?

2. Where is Sis. Mary Brown in the tasks of mourning?

3. What are some ways you can help Sis. Brown to begin the tasks of mourning.

4. Is this a normal grief reaction?

PART II - PSYCHIATRY AND BEREAVEMENT:
An Introduction to Psychiatry Training Session
Dr. Jeffery Grace, Instructor

I. OVERVIEW: PSYCHIATRIC ILLNESS/INTRODUCTION

- Definitions of "mental illness" are imprecise

- Broad spectrum of human emotion and behaviors are **UNIVERSAL**

- Mental disorder (definition):

Clinically significant behavioral or psychological syndrome or pattern (dysfunction) that occurs in an individual and is associated with either -
♦ *present distress (pain)*
♦ *disability (social, work, relationships, leisure)*
♦ *increased risk of suffering death, pain, disability, or an important loss of freedom*
♦ *excludes culturally sanctioned responses or antisocial behavior*

ACTIVITY ONE

Name three examples of family, friends, or community persons who meet the definition of having a mental disorder.

1. _____
   _____
2. _____
   _____
3. _____
   _____

GOAL OF ACTIVITY:

- universal experience of mental disorder
- decrease stigma related to discussing emotional problems

II. DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDER - IV

- Manual developed by American Psychiatric Association
- Guideline for Mental Health profesionals and others for diagnosis, communication, and research.
- Developed in coordination with the World Health Organization and its' International Statistical Classification of Diseases and Realted health Problems (ICD-9).
- Diagnostic Classes
  - (1) Disorders usually first diagnosed in infancy, childhood, adolescence
  - (2) Delirium, Dementia and Amnestic and other Cognitive Disorders

(3) Mental disorder due to a General Medical condition not elswere classified
(4) Substance-Related Disorders
(5) Schizophrenia and other psychotic disorders
(6) Mood Disorders
(7) Anxiety Disorders
(8) Somatoform Disorders
(9) Factitions Disorders
(10) Dissociative Disorders
(11) Sexual and Gender Identity Disorders
(12) Eating Disorders
(13) Sleep Disorders
(14) Impulse-Control Disorder not elsewhere classified
(15) Adjustment Disorders
(16) Personality Disorders
(17) Other conditions that may be a focus of Clinical Attention

III. GRIEF REACTION - BEREAVEMENT

- Focus of Clinical Attention is a brief and appropriate reaction to the death of a loved one.
  - ♦ Major depression symptoms
    - sadness
    - insomnia
    - poor appetite
    - weight loss
  - ♦ Variable durations

- Pathological grief
  - ♦ Depression persists for more than 2 months (Major Depression)
  - ♦ Guilt about things not related to death
  - ♦ Thoughts of death not realted to feeling of being better off or joining
  - ♦ the deceased person
  - ♦ Morbid worthlessness preoccupation

- Prolonged functional impairment
- Odd hallucinations

- **Treatment**

  - Supportive psychotherapy
  - Pharmacotherapy that is symptom targeted (i.e., for insominia or anxiety) and given for a short period of time.

ACTIVITY TWO

Describe your feelings at the funeral of ...

1. a close friend _____
   _____
   _____

2. a church member's relative who you have never met _____
   _____
   _____
   _____

3. a relative such as a parent, child, or spouse _____
   _____
   _____
   _____

GOAL

Discussion of normal grief reactions and pathological responses to grief.

ACTIVITY THREE

Case Example – Grief Reaction

On the day before Pete's 16th birthday, he was admitted to the psychiatric unit of a general hospital in the wealthy Detroit suburb in which he lives. He had slashed his wrist with a butcher knife, severing nerves and tendons in his left hand, and drifted in and out of consciousness during the night, finally calling a friend's mother for help in the morning.

Pete is the son of a Vietnamese mother and an American seviceman. He lived with his mother in Saigon until he was 2, when he came to the United States to be adopted by an American family through an agency specializing in adoption of Vietnamese children. He was apparently abused (burned and beaten) in his family, removed to a foster home for a brief period, and, at age 2-1/2, placed with his current adoptive parents.

Although always somewhat reserved and uncommunicative with his adoptive parents, Pete initially did well in his new surroundings. He was a bright, quiet and beautiful little boy who was sought out by other children from the time he started school. He always got along well with his friends, but his relationship with his parents was stormy, and they describe him as the most difficult of the four children they have adopted.

By the time he was in junior high, Pete was hanging out with a group of long-haired, counter-culture kids who skipped school to smoke marijuana, considered nihilism a philosophy of life, shoplifted beer from the local supermarket, and disparaged the values of their parents and teachers. His grades dropped, and he got into trouble for shooting at squirrels with his BB gun, blowing up mailboxes with firecrackers, and fighting with the "jocks" from his school.

When Pete was 14, his parents separated; he elected to stay with his father rather than move with his mother and siblings to another state. His misdemeanors escalated. He and his friends were picked up for "borrowing" the car of a vacationing neighbor to go joyriding. By 15 he was truant more days than he was in school, and was using any drug he and his friends could get hold of – mostly LSD, mescaline, glue, and marijuana. His parents sent him away to military school, but he had been expelled the month before his admission to the hospital because he never attended classes.

On Admission Pete is described as an immensely appealing, waif-like young man who was immediately adored by every adolescent girl on the ward. He says that he did not intend to kill himself when he slashed his wrist. When pressed, he finally tells the following story: He was dropping acid with some friends. After they left, he thought he heard a police siren. Thinking to save himself from being arrested, he slashed his wrist, and then lost consciousness. He denies being depressed, but says his life is pointless and it makes no difference whether he lives or dies.

ACTIVITY FOUR

Video Scenes

- Terms of Endearment
- Crooklyn

IV. DSM-IV CRITERIA: ADJUSTMENT DISORDER

Diagnostic criteria for Adjustment Disorders

A. The development of emotional or behavioral symptoms in response to an identifiable stressor(s) occurring within 3 months or the onset of the stressor(s).

B. These symptoms or behaviors are clinically significant as evidenced by either of the following:
   (1) marked distress that is in excess of what would be expected from exposure to the stressor
   (2) significant impairment in social or occupational (academic) functioning

C. The stress-related disturbance does not meet the criteria for another specific Axis I disorder and is not merely an exacerbation of a preexisting Axis I or Axis II disorder.

D. The symptoms do not represent Bereavement.

E. Once the stressor (or its consequences) has terminated, the symptoms do not persist for more than an additional 6 months.

Specify if: **Acute:** if the disturbance lasts less than 6 months
Chronic: if the disturbance lasts for 6 months or longer

Adjustment Disorders are coded based on the subtype, which is selected according to the predominant symptoms. The specific stressor(s) can be specified on Axis IV

309.0	With Depressed Mood
309.24	With Anxiety
309.28	With Mixed Anxiety and Depressed Mood
309.3	With Disturbance of Conduct
309.4	With Mixed Disturbance of Emotions and Conduct
309.9	Unspecified

V. MAJOR DEPRESSION

- **Criteria for Major Depressive Episode**

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either
   - ♦ depressed mood or
   - ♦ loss of interest or pleasure

> *Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.*

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** *In children and adolescents, can be irritable mood.*

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others).

(3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** *In children, consider failure to make expected weight gains.*

(4) insomnia or hypersomnia nearly every day

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day

(7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely

self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for commiting suicide

B. The symptoms do not meet criteria for a Mixed Episode

C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

E. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness suicidal ideation, psychotic symptoms, or psychomotor retardation.

ACTIVITY FIVE

CASE STUDY - EVIL SPIRITS AND FUNERAL CARS

A 28-year-old woman from Surinam, South America (Dutch Guinea), now living in Amsterdam, is referred to a psychiatrist. Her social worker and her family doctor are worried because she sees funeral cars everywhere and says she want to commit suicide. Moreover, sometimes she suddenly starts to tremble violently, her eyeballs roll upward, her arms and hands twist, and she utters strange words and no longer understands Dutch. After 5 minutes she regains consciousness, and it is possible to get in contact with her. She does not remember anything that happens during these attacks, but behaves as if she has undergone an exhausting experience.

The patient tells the psychiatrist that since she came to the Netherlands 7 years ago, she has been haunted four times by evil spirits, who push her "good spirits" aside and take over her body. Two of these spirits always come back during difficult periods and want her dead. One has the body of a frog, with a dog's head with horns; the other is a tall man with a white hat and white gloves. During these crises she also suffers from headache, back pain, abdominal pain, or chest pain. She also has sleeping problems and a lack of energy and appetite, and she broods. Occasionally she has "foam" in her mouth, which is an omen of death; at times she has "panting attacks."

At first the patient consulted her family doctor, who cured her panting attacks with a relaxation technique. She consulted two Surinamese diviners/healers in Amsterdam. A ritual was performed, after which her spirits were placated, and all her complaints disappeared. These episodes were apparently connected with problems concerning her family in Surinam, who made her feel she was badly needed there, or with disputes with her siblings in the Netherlands.

Since her arrival in the Netherlands, the patient has worked at cleaning jobs, and finally got a position in the linen room of a hospital. She became acquainted with a Dutchman working in the hospital; after she got pregnant, they decided to marry. Despite her taking birth-control pills meticulously after the delivery, she became pregnant again. Her request to work part time was initially refused. She made an appeal to the personnel manager, who gave her a part-time job. However, by that time relations with her own supervisor were so disturbed that she was dismissed. For the first time since her arrival in the Netherlands, she became economically dependent on her husband, who now forced her to justify all her expenses.

After the delivery of the unplanned baby, the patient again visited her family doctor, with a feeling of increasing fatigue in both arms, pain under her breasts, and pain behind her left breasts, which at times radiated to her back. She felt too tired to take care of her children or to make love with her husband.

Now, 3 months later, the patient has pain everywhere, is frightened, cannot sleep, and feels feeble. She continually sees funeral cars following her, and she ruminates about killing herself. Treatment with haloperidol results in a heavy and dizzy sensation, and has to be stopped after 1 day.

The patient tells the psychiatrist that she visited a Surinamese diviner and a Hindustani healer, who both told her that her soul had been robbed, that it was too late do anything, and that she was going to die. Then her brother took her to a female diviner, a "*winti*-woman." This woman diagnosed her problem as the result of neglect of her ancestral spirits, who sought revenge; she gave the patient a bath with herbs, tore a white sheet into two parts over her body, smashed an egg on her head, and removed

the mucus from her mouth, so that the evil spirits would leave her body. The treatment worked well. The patient felt much better, and could stand and walk again. The "*lukuwoman*" told her to go back to Surinam to strengthen her divining power by giving a family feast for the ancestral spirits. The patient also saw a Roman Catholic pastoral worker and a Rosicrucian.

The woman tells her psychiatrist that for the first time, the evil spirits are walking about her house. The spirits resemble gray-red nebulous beings, who off and on present as a red eye or as the aforementioned frog with the dog's head. At other times she sees auguries of death, such as a white floating sheet or the tall man wit h the white hat and white golves. When she is scared, she cannot chase them away. She sees the cemetery where the funeral cars will take her; she hears the bell of her house chime; she cannot sleep because the frog changes into a little red ball with teeth that sucks her blood as soon as she goes to sleep. She eats the way she always has, but the spirits consume her, so that she has lost more than 22 pounds. Her menstruation has become irregular. Sometimes she feels as if her body is changed and that she smells bad, like death itself.

The tall man with the white hat wants to have intercourse, and sometimes lies upon her. Just when she dozes off, he tries to rape her. She wakes up, cannot move, and feels terribly scared. He presses heavily upon her heart (she indicates her breast bone), and suckers her nipples as if they were making love. He empties her breasts in the same way as a baby drinks milk. Her breasts have become totally flat; all that remains is a little piece of skin.

Once before, during one of her sick episodes, she had a similar ecperience. She had seen a diviner, who told her that somebody had cast a spell on her by sending a dwarf. Just when she was dozing off and her soul had left her body, the dwarf sat down heavily on her breast and tried to choker her by pressing her throat. But her soul was floating in the room, and saw her body lying on the bed. Her soul told her, "They have got your heart; hear how it bounces." She thought she was going to die; and when the episode passed, she was so scared that she wanted to sleep in her husbands arms.

In addition to the evil spirits who pester her and who threaten to harm her children, the patient hears her ancestors' voices encouraging her to stand up. Her husband explains to the psychiatrist that he will not participate in the therapy. Over the past few years they have spent an enormous amount of money on diviners. He is fed up with her stories about spirits, her insistence that he has to enter his house backward, and her interpretation of every draft in the house as the presence of spirits.

VI. BRIEF PSYCHOTIC DISORDER

A. Presence of one (or more) of the following symptoms:
   (1) delusions
   (2) hallucinations
   (3) disorganized speech (e.g., frequent derailment or incoherence)
   (4) grossly disorganized or catatonic behavior

   Note: Do not include a symptom if it is a culturally sanctioned response pattern.

B. Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning.

C. The disturbance is not better accounted for by a Mood Disorder With Psychotic Features, Schizoaffective Disorder, or Schizophrenia and is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

Specify if:

With Marked Stressor(s): (brief reactive psychosis): if symptoms occur shortly after and apparently in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in person's culture.

Without Marked Stressor(s): if psychotic symptoms do not occur shortly after, or are not apparently in response to events that, singly or together, would be markedly stressful to almost anyone in similar circumstances in the person's culture

With Postpartum Onset: if onset within 4 weeks postpartum

ACTIVITY SIX - CASE DISCUSSION - THE SOCIALITE

Dorothea Cabot, a 42 year old socialite, has never had any mental problems before. A new performance hall is to be formally opened with the world premiere of a new ballet: Dorothea, because of her position on the cultural council, has assumed the responsibility for coordinating that event. However, construction problems, including strikes, have made it uncertain whether finishing details will meet the deadline. The set designer has been volatile, threatening to walk out on the project unless the materials meet his meticulous specifications. Dorothea has had to calm this volatile man while attempting to coax disputing groups to negotiate. She has also had increased responsibilities at home as her nanny has had to leave to visit a sick relative.

In the midst of these difficulties, her best friend has been decapitated in a tragic auto crash. Dorothea herself is an only child, and her best friend had been very close to her since grade school. People have often commented that the two women were like sisters.

Immediately following the funeral, Dorothea becomes increasingly tense and jittery, and able to sleep only 2-3 hours a night. Two days later she happens to see a woman driving a car just like the one her friend had driven. She is puzzled, and after a few hours she becomes convinced that her friend is alive, that the accident had been staged along with the funeral, as part of a plot. Somehow the plot is directed toward deceiving her, and then she senses that she is in great danger and must solve the mystery to escape alive. She begins to distrust everyone except her husband, and begins to believe that the phone is tapped and that the rooms are "bugged." She pleads with her husband to help save her life. She begins to hear a high-pitched, undulating sound, which she fears is a ultra-sound beam aimed at her. She is in a state of sheer panic, gripping her husband's arm in terror, as he brings her to the emergency room the next morning.

A. Characteristic symptoms: Two (or more) of the following, each present for a significant portion of time during a 1 month period (or less if successfully treated):

(1) delusions
(2) hallucinations
(3) disorganized speech (e.g., frequent derailment or incoherence)
(4) grossly disorganized or catatonic behavior
(5) negative symptoms, i.e., affective flattening, alogia, or avolition

Note: Only one Criterion A symptom is required if delusions are bizarre or hallucinations consist of a voice keeping up a running commentary on the person's behavior or thoughts, or two or more voices conversing with each other.

B. Social/occupational dysfunction: For a significant portion of the time since the onset of the disturbance, one or more major areas of functioning such as work, interpersonal relations, or self-care are markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, failure to achieve expected level of interpersonal, academic, or occupational achievement).

C. Duration: Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or two or more symptoms listed in Criterion A present in an attenuated form (e.g. unusual perceptual experiences)

D. Schizoaffective and Mood Disorder exclusion: Schizoaffective Disorder and Mood Disorder with Psychotic Features have been ruled out because either

(1) no Major Depressive, Manic, or Mixed Episodes have occurred concurrently with the active-phase symptoms: of

(2) if Mood episodes have occurred during active-phase symptoms, their total duration has been brief relative to the duration of the active and residual periods.

E. Substance/general medical condition exclusion: The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition.

F. Relationship to a Pervasive Developmental Disorder: If there is a history of Autistic Disorder or another Pervasive Developmental Disorder, the additional diagnosist of Schizophrenia is made only if prominent delusions or hallucinations are also present for at least a month (or less if successfully treated).

ACTIVITY SEVEN

CASE DISCUSSION: VIDEO PRESENTATION - SCHIZOPHRENIA

Identify

- Hallucinations
- Delusions
- Inappropriate Affect

VIII. SUBSTANCE-RELATED DISORDER

A. Mental disorder related to taking:

(1) drugs of abuse
- alcohol
- heroin opiates
- cocaine

(2) medications
- Valium
- Opiates

(3) toxin exposure
- lead
- volatile substance

B. Disease Concept:

> *Substance related disorders are not merely character flaws for which the individual is to be blamed. A variety of factors including genetic, familiar patterns, biological as well as psychosocial factors, contribute to the illness of chemical dependency.*

C. Substance-Related Disorder - Two Groups

Substance Use Disorders

- Dependence
- Abuse

- Intoxication
- Withdrawal
- Delirium
- Persisting Dementia
- Persisting Anesia
- Persisting Hallucinogen - perception disorder (flashbacks)
- Psychosis
- Mood Disorder
- Anxiety
- Sexual Dysfunctions
- Sleep Disorder

D. Treatment

- Self Help (12 step program) groups
- Sponsor
- Counseling/Psychotherapy
- Rehabilitation Programs
- Half Way House
- Agonist/Antagonist Therapy
- Pharmacotherapy

E. Criteria for Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

(1) tolerance, as defined by either of the following:
  (a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
  (b) markedly diminished effect with continued use of the same amount of the substance

(2) withdrawal, as manifested by either of the following:
  (a) the characteristic withdrawal syndrome for the substance (refer to Criteria A and B of the criteria sets for Withdrawal

from the specific substances)

(b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms

(3) the substance is often taken in larger amounts or over a longer period than was intended

(4) there is a persistent desire or unsuccessful efforts to cut down or control substance use

(5) a great deal of time is spent in activities necessary to obtain the substance (e.g. visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects

(6) important social, occupational, or recreational activities are given up or reduced because of substance use

(7) the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Specify if:

With Physiological Dependence: evidence of tolerance or withdrawal (i.e., either item 1 or 2 is present)

Without Physiological Dependence: no evidence of tolerance or withdrawal (i.e., neither item 1 nor 2 is present)

F. Criteria for Substance Abuse

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12-month period:

(a) recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated

absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household)

(b) recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use.

(c) recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct)

(d) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of substance (e.g., arguments with spouse about consequences of intoxication, physical fights)

2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

ACTIVITY EIGHT

---

1. Discussion of video case of substance-related disorder

2. Discussion of case

IX. PSYCHIATRIC TREATMENT AND REFERRAL

- A full discussion of psychological and psychopharmacological (medications) interventions is beyond the scope and intent of this lecture.

- Major feature of psychiatric treatment include:

  - Individual psychotherapy (talking)

    - ♦ supportive
    - ♦ cognitive
    - ♦ dynamic
    - ♦ psycoeducational
    - ♦ behavioral
    - ♦ social skills building

  - Group psychotherapy
  - Behavioral Therapy
  - Psychiatric Rehabilitation Therapy
  - Family Therapy

- Medications are often helpful when used under the direction of a competent physician.

  - ♦ Depression .....Antidepressants

  - ♦ Psychosis.....Antipsychotic

  - ♦ Mania.....Antimanic agents

  - ♦ Anxiety.....Antiolytics

- Psychiatric treatment is traditionally appropriate when the compliants or behavioral problems significantly interfers with work, school, social, relationship, or living aspects of the individual or family.

- Referral to a mental health professional for any major emotional problem is always appropriate. Psychiatric treatment or consultation offers the individual choices, and may identify helpful options that many are either unaware of or forget in face of a life crisis.

- **INFORMATION AND SUPPORT GROUPS**

  - REACH: For family members of individuals with mental illness
  - Unity Club of Manic Depressive & Depressives
    Contact - Mental Health Associal of Erie County - 886-1242
  - New depression support group forming at Indendent Living Center 836-0822
  - Alliance for the Mentally Ill or Buffalo & Erie County - 877-9415
  - Crisis Services - 834-3131
  - Mental Health Association in Niagara County - 433-3780

- **REFERENCES**

(1) DSM-IV APA, 1994

(2) DSM-IV Casebook, APA, 1994

(3) Viederman, Milton:
Grief: Normal and Pathological Variants. Am J. Psychiatry 1995; 152: 1-4

PART IV - GRIEF COUNSELING

Dr. Lorraine E. Peeler, Instructor

A. Grief Counseling vs. Grief Therapy

- Grief counseling = involves helping people facilitate uncomplicated, or normal, grief to a healthy completion of the tasks of grieving within a reasonable time frame.

- Grief therapy = involves specialized techniques which are used to help people with abnormal or complicated grief reactions.

NOTE
Historically, grieving has been facilitated through the family, the church, and in funeral rituals and other social customs. It is our goal is to utilize all available techniques to better assist those in the church who are grieving.

B. Goals of Grief Counseling

- Overall goal is to help the survivor complete any unfinished business with the deceased.

- Specific Goals which correspond to the tasks of grieving are:

  (1) To increase the reality of the loss;
  (2) To help the counselee deal with both expressed and latent affect;
  (3) To help the counselee overcome various impediments to readjustment after the loss;

(4) To encourage the counselee to make a healthy emotional withdrawal from the deceased and to feel comfortable reinvesting that emotion in another relationship.

C. Who Does Grief Counseling

(1) Professionals - trained doctors, nurses, psychologiest, or social workers;

(2) Volunteers - church leaders and laypersons, community outreach workers - supported by professionals;

(3) Self-help Groups - bereaved people offer help to other bereaved people, with or without the support of professionals.

D. Who Receives Grief Counseling
Three philosophies/approaches:

(1) Universal Model - Counseling should be offered to all individuals, particularly to families in which the death has taken a parent or child.

(2) Crisis Model - Counseling should be offered to those who need help, but wait until they get into difficulty before they ask for help.

(3) Preventive model - Predict those who are potentially high risk for complications in their grieving process and provide counseling.

ACTIVITY ONE

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1. Check the model/approach you agree with the most and give a brief explanation why.

_____ Universal Model _____ Crisis Model _____ Preventive Model

Explain _____

_____

_____

2. Rate from highest (5) to lowest (1) the situations you think are at the highest risk of complications in their grieving process.

_____ loss of an elderly parent
_____ loss of a three year old child
_____ loss of a husband, and left with three small children
_____ loss of a 15 year old son by violent means
_____ loss of a spouse by cancer

E. Counseling Principles and Procedures

Whatever your philosophy or approach and whatever the setting, there are certain principles and procedures that make grief counseling effective. The following are guidelines to assist you in that process.

- **Principle One: Help the Survivor Actualize the Loss**

  Help the person come to a reality and/or a more complete awareness that the loss has actually occurred. A primarily technique is to get the person to talk about it.

  Questions to ask: Where did the death occur? How did it happen? Who told you about it? Where were you when you heard? What was the funeral like?

- **Principle Two: Help Survivor to Identify and Express Feelings**

  Encourage the survivor to express the feelings despite what they are including - anger, guilt, anxiety and helplessness.

- **Principle Three: Assist Living Without the Deceased**

  Help people accommodate to a loss by encouraging them to make decisions independently. A problem-solving approach may be helpful - be sensitive to the problems the survivor may be facing and how they can be solved.

- **Principle Four: Facilitate Emotional Withdrawal from the Deceased**

  Encourage the survivor, in time, to form new relationships - especially in the case of a spouse. Some people may be hesitant to form these new relationships because they believe this will dishonor the memory of their departed spouse.

- **Principle Five: Provide Time to Grieve**

  Grieving requires time. Each birthday and anniversary can bring back special memories and a sense of loss. Don't rush the person and encourage them to experience the feelings that those days bring. It is part of the healing process.

- **Principle Six: Interpret "Normal" Behavior**

  Many people who are grieving may think they are going "crazy". Help the person understand and interpret "normal" grief reactions.

- **Principle Seven: Allow for Individual Differences**

  The behavioral responses to grieving are many. Don't expect everyone to grieve the same way. If one family member deviates from the rest in their behavior, encourage the family to upset this person's need to express their grief differently.

- **Principle Eight: Provide Continuing Support**

  Provide continual support - be spontaneous as well as calculating in extending your support. For example, if a person has lost a mother and Mother's Day is approaching - this may be a time to offer additional support and comfort.

- **Principle Nine: Examine Defenses and Coping Styles**

  Help the counselee recognize defenses they may put up in the face of the loss, as well as help them to identify coping styles that may help them in this process.

- **Principle Ten: Identify Pathology and Refer**

  Know your limitations as a counselor and know when symptoms that are being displayed are beyond your expertise. Don't be afraid to confer with others (professionals) and don't be afraid to refer to professional sources.

NOTE: The Funeral can help begin the grief counseling process .

1. It can help make real the fact of the loss.

2. The funeral service can give people an opportunity to express thoughts and feelings about the deceased.

3. The service can also be a reflection of the life of the person who is gone.

4. The funeral service has the effect of drawing a social support network close to the bereaved family shortly after the loss has occurred, which can be extremely helpful in the facilitation of grief.

F. Identifying Abnormal Grief Reactions

(1) Why people fail to grieve

- **Relational Factors** - the type of relationship the person had with the deceased.
- **Circumstantial Factors** - how the person died - violent vs. natural causes.
- **Historical Factors** - how the person reacted to losses in the past.
- **Personality Factors** - the person's character - emotional vs. unemotional.
- **Social Factors** -
  - Is the loss socially unspeakable
  - Is it socially negated
  - the absence of a social support network

G. Special Types of Losses

- <u>Suicide</u> - Survivors of suicide victims are not only left with a sense of loss, they are left with a legacy of shame, fear, rejection, anger and guilt, as well as the spiritual and religious implications.
- <u>Anticipatory Grief/Terminally Ill</u> - this refers to the grief that occurs prior to the actual loss, especially when a person first learns of the potential death of a loved one or of their own potential death.

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- Sudden/Violent Death - these are deaths that occur without warning and require special understanding and intervention. These include accidental deaths, heart attacks, and homicides.

- Infant Death - Specifically Sudden Infant Death Syndrome (SIDS) - this occurs in infants under one year of age and frequently found in infants aged two to six months.

- Miscarriages/Still Births - parents who experience miscarriages and still births receive considerable support from family and friends, but not a lot of attention about the actual loss.

- Abortion - many people take a casual attitude regarding the experience of abortion - but there can be some unresolved grief because the experience can rarely be shared, as well as the spiritual/religious implications.

ACTIVITY TWO - REFLECTIONS

Reflections on your own life and losses you experience can help you better serve others in working through their own grief. Please answer the following questions about your own experiences.

1. The first death I can remember was the death of _____ and I was age _____
2. The feelings I remember I had at the time were _____
   _____
3. The first funeral (wake or other ritual service) I ever attended was for _____ _____ I was age _____
4. The thing I most remember about that experience is _____
   _____
5. My most recent loss by death was (Person, time, circumstances) _____
   _____
   _____
6. I coped with this loss by _____
   _____
7. The most difficult death for me was the death of _____
8. It was difficult because _____
   _____
9. Of the important people in my life who are now living, the most difficult death for me would be the death of _____
10. It would be the most difficult because _____
    _____
11. My primary style of coping with loss is _____
    _____
12. I know my own grief is resolved when _____
13. It is appropriate for me to share my own experiences of grief with a counselee when
    _____
    _____

ACTIVITY THREE

- Video vignettes -

  - Boys in the Hood
  - Steel Magnolias
  - My Girl

H. Family Counseling Issues

- Because the family is a "system" the loss of one loved one impacts the whole system. When counseling - we must remember that every family member has been affected and identified Problems (IP's) may arise in various parts of the system.

I. Support Systems

Life Transition Center, Inc. - 3580 Harlem Road - 836-6460
Buffalo Hospice, Inc. - 2929 Main Street - 838-4438
Hospital/Medical Social Workers

J. References

Kubler-Ross, E. (1969) On Death and Dying. New York: Macmillan.

Schiff, Harriet. S. (1977) The Bereaved Parent. New York: Penguin Books.

Worden, William J., (1982) Grief Counseling and Grief Therapy: A Handbook for the Mental Health Practitioner. New York: Springer Publishing Company.

PART V - INTERVENTIONS

Rev. Leslie Braxton, Instructor

I. RITUAL - FUNERAL/WAKE

A. Funerals, wakes, and memorial services are acts of mourning performed by and for the bereaved community. Each is designed to assist the bereaved in dealing with their loss.

Note: Each person has their own perception of a "proper burial" and/or "puttting a loved one away right". It is important to listen to the family as well as assist them in planning appropriately.

ACTIVITY ONE - FUNERAL PLANNING

When planning a loved one's funeral and burial, family members insist upon *"putting them away right or giving them a proper burial"*. List three things that have to occur for a loved one to have been *"put away right"*.

1. _____
   _____
   _____

2. _____
   _____
   _____

3. _____
   _____
   _____

B. A Christian Funeral Service is:

(1) A divine or sacred worship:

(2) A memorial tribute to the righteous life of the deceased:

(3) A spiritual expression of hope for the living:

C. A funeral program should concern itself with:

(1) Paying appropriate honor and tribute to the life of the deceased:

(2) Bringing consolation to the grieving family and friends:

(3) Reaffirmation of the grieving community's faith in the love and purposes of Almighty God.

ACTIVITY TWO

What is the difference between a wake, a funeral, and a memorial service?

A wake is: _____

_____

_____

_____

_____

A funeral is: _____

_____

_____

_____

_____

A memorial service is: _____

_____

_____

ACTIVITY THREE

CASE STUDY

Sis. Minnie Johnson has been a pious, faithful, and declated member of the church for over 30 years. Yesterday, she lost her son to a violent death related to drugs. While living, Sis. Johnson's son never came to church as an adult and was a well-known drug dealer/pimp. He was suspected of having commited murder on occasion related to his drug activities as well as abusing and battering women. Sis. Johnson asked the Pastor if the funeral for her son could be held at the church and would he officiate. The Pastor at this time is hesitant in giving Sis. Johnson a reply.

DISCUSSION QUESTIONS

1. Should the church/Pastor be concerned with the character of Sis. Johnson's life or the character of her son's life?

2. Does the church send the "wrong" message to the community when it funeralizes a person who had been openly "wicked" during their life?

3. Is there ever a time when the church should refuse a person's request to have their loved one funeralized at the church? Explain.

AFTER CARE

A. Diaconate follow-up (short term care)

1. Personal visits (6): To begin immediately
After funeral
3 weekly
3 bi-weekly

Objectives:
- Actualize goals of grief counseling
- Observe 10 principles of Grief Counseling (p. 37-39)
- encourage the bereaved to participate in the grief support group ministry for long term care.

2. Be mindful of the bereaved's special dates: ie.
- Birthday of deceased
- Anniversary dates
- Holidays

B. Grief support group (long term care)

1. Participants:
- Shall be bereaved persons from within the congregation and the community.
- shall be "at least" six weeks removed from the date of the death.
- shall attend a bi-weekly meeting, 1 hour in length.
- shall be encouraged to participate in the support group ministry for a full year.

Objective:
Although the grief process may in many cases take a few years for completion, the support group ministry will attempt to facilitate healthy grieving and progress toward grief resolution within the year term.

C. When to refer for additional help

THE WAKE AND FUNERAL PROCEDURE
OF THE
FIRST SHILOH BAPTIST CHURCH
BUFFALO, NEW YORK

1.	**The Pastor is to be notified, immediately, through the church office;**
2.	**No funeral plans, time or date should be confirmed until after consultation with the Pastor;**
3.	**After the time, date and location of the funeral has been confirmed, with the Pastor, the Funeral Committee shall be notified to:** **a. coordinate the musical program, for both the wake service and the funeral;** **b. provide usher coverage for the funeral service;** **c. assist the family with the development of the obituary.** **d. develop funeral service format in consultation with the family (ie, solicit family song and scripture requests.) The funeral program must be approved by the Pastor before being finalized and sent to print.** **e. coordinate after-service meal;**
4.	**The body of the deceased may be brought to the church at least two (2) hours before the funeral for visitation, review and final tribute and respect;**
5.	**The review of the remains is done at the beginning of the service.**
6.	**The casket is always closed before the service begins and is not opened during or at the end of the service.**
7.	**The family is instructed to read the following passages:** **OLD TESTAMENT: Psalm 46 and 90; Job 14; Isaiah 40** **NEW TESTAMENT: Gospel of John 14; I Corinthians 13 & 15; Revelations 7**

SHILOH FUNERAL PROGRAM

MUSICAL PRELUDE

PROCESSIONAL

***INVOCATION** **(MINISTER)**

CONGREGATIONAL
OR CHOIR SONG

***SCRIPTURE READING** **(MINISTER OR DEACON)**
OT
NT

***PRAYER OF COMFORT** **(MINISTER OR DEACON)**

REMARKS
(FRIENDS OF FAMILY, COMMUNITY REP.
POLITICIANS, ETC.)

ACKNOWLEDGMENTS

RESOLUTION

READING OF OBITUARY

SONG

EULOGY

RECESSIONAL

***DESIGNATED BY PASTOR OR OFFICIATING MINISTER**
NEEDED FROM THE FAMILY:
DESIRED MUSICAL SELECTIONS
DESIRED SCRIPTURE READINGS
ANY OTHER SPECIAL FEATURES
NOTE: ALL ASPECT OF THE PROGRAM MUST BE APPROVED BY PASTOR

GRIEF INTERVENTION TRAINING ASSESSMENT SCALE
(Pre-Test)

(Rev. Braxton, Dr. Grace, Rev. Peeler)

Please answer these questions as quickly as you can. The goal is to introduce you to some concepts of grief counseling and obtain a baseline understanding for future training. Circle the single best response.

		Circle One
1.	Suicide often occurs as a grief reaction.	True False
2.	Depression (sad feeling) is a common feeling accompanying death of a loved one.	True False
3.	Hearing or seeing the deceased 6 months after their death is a common part of the grief reaction.	True False
4.	A recommendation to see a psychotherapist or a counselor is always appropriate.	True False
5.	You would recommend drinking to relieve tension following notice that a loved one has died.	True False
6.	Sad feelings that disrupt your work, school, or relationship for more than 2 months is typical of bereavement.	True False
7.	Mental illness includes culturally sanctioned responses like rage response at the time of a funeral.	True False
8.	The DSM-IV is a type of cookbook for mental health professionals.	True False
9.	Morbid worthlessness preoccupations are expression of normal grief reactions.	True False
10.	Disorganized speech and fears that evil spirits are attacking you can be expected as part of brief psychotic disorders.	True False
11.	Schizophrenia is a mental disorder that typically includes a split or multiple personality.	True False
12.	I would feel comfortable offering support and biblical reading to a church member who is experiencing the death of her son due to AIDS.	True False

13.	I am usually at a loss for words when I face someone who has just lost a loved one.	True False
14.	I always ask if I can do something for the person who has lost a loved one.	True False
15.	Because you can catch AIDS by talking to someone with the disease I avoid anyone I think has the disease.	True False
16.	If someone is not "saved" and they are dying it is not my job to do anything with them. Someone else will get to them.	True False
17.	If I discover that a man is dying of AIDS when I go to pray for him, it is appropriate that I discuss all of his sins and tell him I will not be able to see him again because I disagree with his life style.	True False
18.	A mother is dying of cancer and has two small children (less than 5 years old) I should encourage the father to bring the children to the funeral.	True False
19.	The stronger you are spiritually, the less you'll grieve at the death of a loved one.	True False
20.	I would be willing to go into an impoverished, high crime neighborhood to offer support and Bible reading to a grieving church member.	True False
21.	If an adult member who lost their mother years ago still refuses to come to worship each Mother's Day, then something is "wrong with them."	True False
22.	Putting flowers on the church Altar at the anniversary of a loved ones death each year is a good thing to do.	True False
23.	A funeral should be quick, calm, and avoid emotional stimulation.	True False
24.	A funeral that is quick, calm and avoids emotional stimulation is evidence of persons in denial.	True False
25.	In a "Christian" funeral only an ordained or licensed clergy can give the eulogy.	True False
26.	AIDS is God's curse against homosexuals.	True False
27.	The "unsaved" and "unchurched" should be funeralized at the funeral parlor rather than at the church.	True False
28.	A deceased member's family must make a donation to the church for performing the funeral service for the family.	True False

29.	Making funeral preparations (including the funeral program) prior to death is a death wish upon the individual.	True False
30.	It's disrespectful to wear a green suit to a funeral.	True False
31.	Masons, Eastern Stars, and other fraternal organizations should perform their group rituals only at the wake.	True False
32.	A married man who had a heart attack and died in his mistresses arms should be funeralized at the funeral parlor rather than at the church.	True False
33.	When visiting the terminally ill, I should always ask them if they've repented of their sins and accepted Jesus Christ in their heart."	True False
34.	It is inappropriate to "open the doors of the church" during a funeral.	True False
35.	The casket should remain open during a funeral.	True False
36.	It is natural for people to form close attachments with persons other than blood relatives.	True False
37.	People grieve the loss of a loved one because they are emotionally bonded to them.	True False
38.	A person grieves more when they lose a loved one who lives in the same city as they do.	True False
39.	A person should be encouraged to subdue their emotional reaction to the loss of a loved one.	True False
40.	Parents should be encouraged to subdue their emotional reactions to the loss of a loved one in front of their children.	True False
41.	There is a specific time and a specific wasy a person should mourn.	True False
42.	A year after the loss of her husband a young widow refuses to date. I should encourage her to begin dating again.	True False
43.	Some normal feelings associated with grief are: guilt, loneliness, relief, and joy.	True False
44.	A man complains about tightness in his chest, lack of energy and dry mouth a week after the loss of his wife. I should encourage him to call his family physician.	True False
45.	There is a difference between grief and depression.	True False

46.	I believe a person should try to get active as soon as possible after the loss of a loved one.	True False
47.	A person should try not to be alone when they grieve. The more people around the better.	True False
48.	Men should try to be strong and not show emotion when they have lost a loved one.	True False
49.	When an elderly person dies, the family should not grieve as much because that person has lived a long life.	True False
50.	A family should not spend a lot of money on a baby's funeral.	True False
51.	A husband and wife have a right to grieve a miscarriage.	True False
52.	Suicide is an unpardonable sin, and I should inform them of this when a loved one has committed suicide.	True False
53.	When a loved one is terminally ill, the family should try not to grieve until they actually die.	True False
54.	People from different cultural backgrounds grieve differently.	True False
55.	How I grieve is the right way to grieve.	True False
56.	It's okay for a woman to get emotional when a loved one dies, but a man should be strong at any cost.	True False
57.	When a bad person dies, their family should grieve.	True False
58.	Good people should live longer than bad people.	True False
59.	Poor families should not spend a lot of money on funerals.	True False
60.	Funeral Directors know how much a family should spend on the funerals of their loved ones.	True False
61.	After the death of a loved one, their name should not be mentioned in jest.	True False

•Please answer these questions as fully as you are able.

1. If a terminally ill member of the church quoted James 5: 14-15 and asked you to lay hands on them and "pray the prayer of faith" over them to heal them, what would you do?

2. A recently widowed woman comes to you and says "Deacon, I know I should be strong, but I just can't stop crying when I think about him!" What would you say to her?

3. If a ten year old child who has just lost their father asked you "Deacon, why did God take my daddy away?" How do you respond?

4. An obviously gay man asks you to ask the Pastor if he will perform the funeral for their deceased lover who died of AIDS. In your opinion, should the Pastor perform this funeral?

5. How would you prepare yourself to visit a church member who has recently experienced the death of a loved one?

GRIEF INTERVENTION TRAINING ASSESSMENT SCALE
(Post-Test)

(Rev. Braxton, Dr. Grace, Rev. Peeler)

In answering the following questions, think about your experiences and feelings during the training period. Circle the single best response.

		Circle One
1	You would recommend drinking to relieve tension following notice that a loved one has died.	True False
2	The DSM-IV is a type of cookbook for mental health professionals.	True False
3	Parents should be encouraged to subdue their emotional reactions to the loss of a loved one in front of their children.	True False
4	Disorganized speech and fears that evil spirits are attacking you can be expected as part of brief psychotic disorders.	True False
5	I would feel comfortable offering support and biblical reading to a church member who is experiencing the death of her son due to AIDS.	True False
6	I always ask if I can do something for the person who has lost a loved one.	True False
7	A recommendation to see a psychotherapist or a counselor is always appropriate.	True False
8	A year after the loss of her husband a young widow refuses to date. I should encourage her to begin dating again.	True False
9	Because you can catch AIDS by talking to someone with the disease I avoid anyone I think has the disease.	True False
10	Sad feelings that disrupt your work, school, or relationship for more than 2 months is typical of bereavement.	True False
11	If someone is not "saved" and they are dying it is not my job to do anything with them. Someone else will get to them.	True False
12	A mother is dying of cancer and has two small children (less than 5 years old) I should encourage the father tobring the children to the funeral.	True False
13	The stronger you are spiritually, the less you'll grieve at the death of a loved one.	True False
14	AIDS is God's curse against homosexuals.	True False
15	If I discover that a man is dying of AIDS when I go to pray for him, it is appropriate that I discuss all of his sins and tell him I will not be able to see him again because I disagree with his life style.	True False

16	Funeral Directors know how much a family should spend on the funerals of their loved ones.	True	False
17	I would be willing to go into an impoverished, high crime neighborhood to offer support and Bible reading to a grieving church member.	True	False
18	A funeral should be quick, calm, and avoid emotional stimulation.	True	False
19	Schizophrenia is a mental disorder that typically includes a split or multiple personality.	True	False
20	A family should not spend a lot of money on a baby's funeral.	True	False
21	It's okay for a woman to get emotional when a loved one dies, but a man should be strong at any cost.	True	False
22	I am usually at a loss for words when I face someone who has just lost a loved one.	True	False
23	If an adult member who lost their mother years ago still refuses to come to worship each Mother's Day, then something is "wrong with them."	True	False
24	Depression (sad feeling) is a common feeling accompanying death of a loved one.	True	False
25	Putting flowers on the church Altar at the anniversary of a loved ones death each year is a good thing to do.	True	False
26	It's disrespectful to wear a green suit to a funeral.	True	False
27	In a "Christian" funeral only an ordained or licensed clergy can give the eulogy.	True	False
28	The "unsaved" and "unchurched" should be funeralized at the funeral parlor rather than at the church.	True	False
29	Good people should live longer than bad people.	True	False
30	Making funeral preparations (including the funeral program) prior to death is a death wish upon the individual.	True	False
31	Masons, Eastern Stars, and other fraternal organizations should perform their group rituals only at the wake.	True	False
32	A married man who had a heart attack and died in his mistresses arms should be funeralized at the funeral parlor rather than at the church.	True	False
33	Suicide often occurs as a grief reaction.	True	False
34	When visiting the terminally ill, I should always ask them if they've repented of their sins and accepted Jesus Christ in their heart."	True	False
35	The casket should remain open during a funeral.	True	False
36	How I grieve is the right way to grieve.	True	False
37	It is natural for people to form close attachments with persons other than blood relatives.	True	False

38	People grieve the loss of a loved one because they are emotionally bonded to them.	True	False
39	A deceased member's family must make a donation to the church for performing the funeral service for the family.	True	False
40	A person should try not to be alone when they grieve. The more people around the better.	True	False
41	Hearing or seeing the deceased 6 months after their death is a common part of the grief reaction.	True	False
42	A person grieves more when they lose a loved one who lives in the same city as they do.	True	False
43	Poor families should not spend a lot of money on funerals.	True	False
44	Mental illness includes culturally sanctioned responses like rage response at the time of a funeral.	True	False
45	There is a specific time and a specific wasy a person should mourn.	True	False
46	Morbid worthlessness preoccupations are expression of normal grief reactions.	True	False
47	When a bad person dies, their family should grieve.	True	False
48	Some normal feelings associated with grief are: guilt, loneliness, relief, and joy.	True	False
49	It is inappropriate to "open the doors of the church" during a funeral.	True	False
50	A funeral that is quick, calm and avoids emotional stimulation is evidence of persons in denial.	True	False
51	After the death of a loved one, their name should not be mentioned in jest.	True	False
52	People from different cultural backgrounds grieve differently.	True	False
53	There is a difference between grief and depression.	True	False
54	I believe a person should try to get active as soon as possible after the loss of a loved one.	True	False
55	Men should try to be strong and not show emotion when they have lost a loved one.	True	False
56	When an elderly person dies, the family should not grieve as much because that person has lived a long life.	True	False
57	A person should be encouraged to subdue their emotional reaction to the loss of a loved one.	True	False
58	A husband and wife have a right to grieve a miscarriage.	True	False
59	Suicide is an unpardonable sin, and I should inform them of this when a loved one has committed suicide.	True	False

60	When a loved one is terminally ill, the family should try not to grieve until they actually die.	True	False
61	A man complains about tightness in his chest, lack of energy and dry mouth a week after the loss of his wife. I should encourage him to call his family physician.	True	False

•Please answer these questions as fully as you are able.

1. If a terminally ill member of the church quoted James 5: 14-15 and asked you to lay hands on them and "pray the prayer of faith" over them to heal them, what would you do?

2. A recently widowed woman comes to you and says "Deacon, I know I should be strong, but I just can't stop crying when I think about him!" What would you say to her?

3. If a ten year old child who has just lost their father asked you "Deacon, why did God take my daddy away?" How do you respond?

4. An obviously gay man asks you to ask the Pastor if he will perform the funeral for their deceased lover who died of AIDS. In your opinion, should the Pastor perform this funeral?

5. How would you prepare yourself to visit a church member who has recently experienced the death of a loved one?

GRIEF CARE TRAINING EVALUATION FORM

Please circle the best answer for each of the following questions.

1. **How many of the six (6) grief care training sessions did you attend?**

   1 2 3 4 5 6

2a. **How do you rate the overall effectiveness of the training sessions in preparing you to better minister to the grieving?**

   Very Helpful Helpful Not Very Helpful Not Helpful At All

2b. **Why?**----------

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3. **How well coordinated was the overall training?**

   Excellent Good Fair Not Good Poor

4. **How do you rate the quality of the grief care training manual that was distributed to all participants?**

   Excellent Good Fair Not Good Poor

5. **How do you rate session #1: Purpose of Training - by Pastor Braxton and Introduction to Grief Theory by Dr. Lorraine Peeler?**

   Very Helpful Helpful Not Very Helpful Not Helpful At All

6. **How do you rate session #2: A Psychiatric Overview by Dr. Jeffrey Grace?**

   Very Helpful Helpful Not Very Helpful Not Helpful At All

GRIEF CARE TRAINING EVALUATION FORM (con't)

7. **How do you rate session #3: Grief Counseling, Part I - The Tasks of Mourning, by Dr. Lorraine Peeler?**

Very Helpful Helpful Not Very Helpful Not Helpful At All

8. **How do you rate session #4: Grief Counseling, Part II - The Goals and Principles of Grief Counseling, by Dr. Lorraine Peeler?**

Very Helpful Helpful Not Very Helpful Not Helpful At All

9. **How do you rate session #5: Interventions and Aftercare, by Pastor Braxton?**

Very Helpful Helpful Not Very Helpful Not Helpful At All

10. **How do you rate session #6: Role Playing, by Dr. Lorraine Peeler and Pastor Braxton?**

Very Helpful Helpful Not Very Helpful Not Helpful At All

Comments:

TABLE 4

Difference between **TOTAL** scores

NOTE: The Value equals the TOTAL Post-Test Score minus the Pre-Test Score. Therefore, a positive value means that the Post-Test Score was higher than the Pre-Test Score. A zero means the same score was received on both tests. A negative value means the Post-Test Score was lower than the Pre-Test Score. Frequency represents the number of participants with a specific score.

Value	Frequency	Percent	Valid Percent	Cum Percent
-11	1	4.2	4.2	4.2
-4	1	4.2	4.2	8.3
-3	3	12.5	12.4	20.8
-2	3	12.5	12.5	33.3
-1	2	8.3	8.3	41.7
0	3	12.5	12.5	54.2
2	1	4.2	4.2	58.3
3	3	12.5	12.5	70.8
4	3	12.5	12.5	83.3
5	1	4.2	4.2	87.5
6	2	8.3	8.3	95.8
9	1	4.2	4.2	100.0
TOTAL	24	100.0	100.0	

Mean	.708
Median	.000
Mode	-3.000
Sum	17.000

* Multiple modes exist. The smallest value is shown.
Valid Cases 24 Missing cases 0

- 11 of 24 participants had higher total scores on the post tests (shaded area under frequency column)
- 10 of 24 participants had higher total scores on the pre-test
- 3 of 24 participants had the same score on the pre- and post-test

TABLE 5

COMPARISON OF PRE NOT IDEAL/POST IDEAL RESPONSES TO PRE IDEAL/POST NOT IDEAL

	* Pre Not Ideal Post Ideal	** Pre Ideal Post Not Ideal	NO CHANGE
Knowledge Questions	8 of 26 questions	2 of 26 questions	16 of 26 questions
Value Questions	8 of 35 questions	9 of 35 questions	18 of 35 questions

* At least 3 (12.5%) more participants had ideal responses on the individual post-test as compared to pre-test questions. See columns 6 & 7 on tables 6 and 7.

** At least 3 (12.5%) more participants had ideal responses on the pre-test questions as compared to post-test.

TABLE 6

#	KNOWLEDGE QUESTIONS	1 Consensus Ideal Response	2 Pre Ideal Post Ideal		3 Pre Ideal Post Not Ideal		4 Pre Not Ideal Post Ideal		5 Pre Not Ideal Post Not Ideal		6 Pre Test Ideal TOTALS		7 Post Test Ideal TOTALS		8 Change Post-test minus Pre-test TOTALS
			#	%	#	%	#	%	#	%	#	%	#	%	#
1	Suicide often occurs as a grief reaction.	F	6	25	4	16.7	5	20.8	9	37.5	10	41.7	11	45.8	NC
2	Depression (sad feeling) is a common feeling accompanying death of a loved one.	T	21	87.5	1	4.2	2	8.3			22	91.7	23	95.8	NC
3	Hearing or seeing the deceased 6 months after their death is a common part of the grief reaction.	F	4	16.7	5	20.8	5	20.8	10	41.7	9	37.5	9	37.5	NC
4	A recommendation to see a psychotherapist or a counselor is always appropriate.	T	5	20.8	10	41.7	1	4.2	8	33.3	15	62.5	6	25	-9
6	Sad feelings that disrupt your work, school, or relationship for more than 2 months is typical of bereavement.	F	3	12.5	4	16.7	3	12.5	14	58.3	7	29.2	6	25.0	NC
7	Mental illness includes culturally sanctioned responses like rage response at the time of a funeral.	F	10	41.7	4	16.7	6	25.0	1	4.2	16	66.7	17	70.8	NC
8	The DSM-IV is a type of cookbook for mental health professionals.	T	8	33.3	1	4.2	10	41.7	4	16.7	9	37.5	19	79.2	10
9	Morbid worthlessness preoccupations are expression of normal grief reactions.	F	7	29.2			8	33.3	8	33.3	7	29.2	15	62.5	8

		1	2		3		4		5		6		7		8
#	KNOWLEDGE QUESTIONS	Consensus Ideal Response	Pre Ideal Post Ideal		Pre Ideal Post Not Ideal		Pre Not Ideal Post Ideal		Pre Not Ideal Post Not Ideal		Pre Test Ideal TOTALS		Post Test Ideal TOTALS		Change Post-test minus Pre-test TOTALS
			#	%	#	%	#	%	#	%	#	%	#	%	#
10	Disorganized speech and fears that evil spirits are attacking you can be expected as part of brief psychotic disorders.	T	13	54.2	2	8.3	7	29.2	1	4.2	16	66.7	20	83.3	4
11	Schizophrenia is a mental disorder that typically includes a split or multiple personality.	F	1	4.2	2	8.3	2	8.3	18	75	3	12.5	3	12.5	NC
15	Because you can catch AIDS by talking to someone with the disease I avoid anyone I think has the disease.	F	24	100							24	100	24	100	NC
19	The stronger you are spiritually, the less you'll grieve at the death of a loved one.	F	18	75.0			3	12.5	3	12.5	18	75	21	87.5	3
24	A funeral that is quick, calm and avoids emotional stimulation is evidence of persons in denial.	F	17	70.8	1	4.2	2	8.3	3	12.5	18	75	20	83.3	NC
25	In a "Christian" funeral only an ordained or licensed clergy can give the eulogy.	F	11	45.8	8	33.3			5	20.8	19	79.2	11	45.8	-8
28	A deceased member's family must make a donation to the church for performing the funeral service for the family.	F	15	62.5	2	8.3	5	20.8	2	8.3	17	70.8	20	83.3	3
30	It's disrespectful to wear a green suit to a funeral.	F	22	91.7	1	4.2	1	4.2			23	95.8	23	95.8	NC

		1	2		3		4		5		6		7		8
#	KNOWLEDGE QUESTIONS	Consensus Ideal Response	Pre Ideal Post Ideal		Pre Ideal Post Not Ideal		Pre Not Ideal Post Ideal		Pre Not Ideal Post Not Ideal		Pre Test Ideal TOTALS		Post Test Ideal TOTALS		Change Post-test minus Pre-test TOTALS
			#	%	#	%	#	%	#	%	#	%	#	%	#
33	When visiting the terminally ill, I should always ask them if they've repented of their sins and accepted Jesus Christ in their heart."	T	8	33.3	2	8.3	10	41.7	3	12.5	11	45.8	18	75	7
34	It is inappropriate to "open the doors of the church" during a funeral.	F	15	62.5	1	4.2			8	33.3	16	66.7	15	62.5	NC
35	The casket should remain open during a funeral.	F	23	95.8	1	4.2					24	100	23	95.8	NC
37	People grieve the loss of a loved one because they are emotionally bonded to them.	T	23	95.8							23	95.8	24	100	NC
38	A person grieves more when they lose a loved one who lives in the same city as they do.	F	15	62.5	4	16.7	2	8.3	3	12.5	19	79.2	17	70.8	NC
43	Some normal feelings associated with grief are: guilt, loneliness, relief, and joy.	T	20	83.3			4	16.7			20	83.3	24	100	4
44	A man complains about tightness in his chest, lack of energy and dry mouth a week after the loss of his wife. I should encourage him to call his family physician.	T	19	79.2	2	8.3	3	12.5			21	87.5	22	91.7	NC
45	There is a difference between grief and depression.	T	20	83.3	1	4.2	2	8.3	1	4.2	21	87.5	22	91.7	NC

		1	2		3		4		5		6		7		8
#	KNOWLEDGE QUESTIONS	Consensus Ideal Response	Pre Ideal Post Ideal		Pre Ideal Post Not Ideal		Pre Not Ideal Post Ideal		Pre Not Ideal Post Not Ideal		Pre Test Ideal TOTALS		Post Test Ideal TOTALS		Change Post-test minus Pre-test TOTALS
			#	%	#	%	#	%	#	%	#	%	#	%	#
54	People from different cultural backgrounds grieve differently.	T	16	66.7			7	29.2	1	4.2	16	66.7	23	95.8	7
60	Funeral Directors know how much a family should spend on the funerals of their loved ones.	F	17	70.8	3	12.5	3	12.5	1	4.2	20	83.3	20	83.3	NC

TABLE 7

		1	2		3		4		5		6		7		8
#	VALUE QUESTIONS	Consensus Ideal Response	Pre Ideal Post Ideal		Pre Ideal Post Not Ideal		Pre Not Ideal Post Ideal		Pre Not Ideal Post Not Ideal		Pre Test Ideal TOTAL		Post Test Ideal TOTAL		Change Post-test minus Pre-test TOTALS
			#	%	#	%	#	%	#	%	#	%	#	%	#
5	You would recommend drinking to relieve tension following notice that a loved one has died.	F	23	95.8	1	4.2					24	100	23	95.8	NC
12	I would feel comfortable offering support and biblical reading to a church member who is experiencing the death of her son due to AIDS.	T	14	58.3	2	8.3	6	25	2	8.3	16	66.7	20	83.3	4
13	I am usually at a loss for words when I face someone who has just lost a loved one.	T	4	16.7	11	45.8	6	25	3	12.5	15	62.5	10	41.7	-5
14	I always ask if I can do something for the person who has lost a loved one.	T	3	12.5	16	66.7			5	20.8	19	79.2	3	12.5	-16
16	If someone is not "saved" and they are dying it is not my job to do anything with them. Someone else will get to them.	F	23	95.8	1	4.2					24	100	23	95.8	NC
17	If I discover that a man is dying of AIDS when I go to pray for him, it is appropriate that I discuss all of his sins and tell him I will not be able to see him again because I disagree with his life style.	F	23	95.8			1	4.2			23	95.8	24	100	NC
18	A mother is dying of cancer and has two small children (less than 5 years old) I should encourage the father to bring the children to the funeral.	T	2	8.3	7	29.2	10	41.7	5	20.8	9	37.5	12	50	3

#	VALUE QUESTIONS	1	2		3		4		5		6		7		8
		Consensus Ideal Response	Pre Ideal Post Ideal		Pre Ideal Post Not Ideal		Pre Not Ideal Post Ideal		Pre Not Ideal Post Not Ideal		Pre Test Ideal TOTAL		Post Test Ideal TOTAL		Change Post-test minus Pre-test TOTALS
			#	%	#	%	#	%	#	%	#	%	#	%	#
20	I would be willing to go into an impoverished, high crime neighborhood to offer support and Bible reading to a grieving church member.	T	20	83.3	3	12.5	1	4.2			23	95.8	21	87.5	NC
21	If an adult member who lost their mother years ago still refuses to come to worship each Mother's Day, then something is "wrong with them."	F	11	45.8	2	8.3	5	20.8	5	20.8	14	58.3	16	66.7	NC
22	Putting flowers on the church Altar at the anniversary of a loved ones death each year is a good thing to do.	T	18	75	2	8.3	3	12.5	1	4.2	20	83.3	21	87.5	NC
23	A funeral should be quick, calm, and avoid emotional stimulation.	F	12	50	2	8.3	4	16.7	6	25	14	58.3	16	66.7	NC
26	AIDS is God's curse against homosexuals.	F	24	100							24	100	24	100	NC
27	The "unsaved" and "unchurched" should be funeralized at the funeral parlor rather than at the church.	F	21	87.5			3	12.5			21	87.5	24	100	3
29	Making funeral preparations (including the funeral program) prior to death is a death wish upon the individual.	F	15	62.5	7	29.2	2	8.3			22	91.7	17	70.8	-5
31	Masons, Eastern Stars, and other fraternal organizations should perform their group rituals only at the wake.	F	9	37.5	3	12.5	5	20.8	6	25	13	54.2	14	58.3	NC

		1	2		3		4		5		6		7		8
#	VALUE QUESTIONS	Consensus Ideal Response	Pre Ideal Post Ideal		Pre Ideal Post Not Ideal		Pre Not Ideal Post Ideal		Pre Not Ideal Post Not Ideal		Pre Test Ideal TOTAL		Post Test Ideal TOTAL		Change Post-test minus Pre-test TOTALS
			#	%	#	%	#	%	#	%	#	%	#	%	#
32	A married man who had a heart attack and died in his mistresses arms should be funeralized at the funeral parlor rather than at the church.	F	23	95.8			1	4.2			23	95.8	24	100	NC
36	It is natural for people to form close attachments with persons other than blood relatives.	T	3	12.5	17	70.8			3	12.5	20	83.3	3	12.5	-17
39	A person should be encouraged to subdue their emotional reaction to the loss of a loved one.	F	21	87.5			2	8.3			21	87.5	24	100	NC
40	Parents should be encouraged to subdue their emotional reactions to the loss of a loved one in front of their children.	F	19	79.2	2	8.3	2	8.3	1	4.2	21	87.5	21	87.5	NC
41	There is a specific time and a specific wasy a person should mourn.	F	21	95.8							24	100	23	95.8	NC
42	A year after the loss of her husband a young widow refuses to date. I should encourage her to begin dating again.	F	17	70.8	4	16.7	1	4.2	2	8.3	21	87.5	18	75	-3
46	I believe a person should try to get active as soon as possible after the loss of a loved one.	T	17	70.8	4	16.7			3	12.5	21	87.5	17	70.8	-4
47	A person should try not to be alone when they grieve. The more people around the better.	T	2	8.3	12	50	4	16.7	6	25	14	58.3	6	25	-8

		1	2		3		4		5		6		7		8
#	VALUE QUESTIONS	Consensus Ideal Response	Pre Ideal Post Ideal		Pre Ideal Post Not Ideal		Pre Not Ideal Post Ideal		Pre Not Ideal Post Not Ideal		Pre Test Ideal TOTAL		Post Test Ideal TOTAL		Change Post-test minus Pre-test TOTALS
			#	%	#	%	#	%	#	%	#	%	#	%	#
48	Men should try to be strong and not show emotion when they have lost a loved one.	F	21	87.5	1	4.2	2	8.3			22	91.7	23	95.8	NC
49	When an elderly person dies, the family should not grieve as much because that person has lived a long life.	F	22	91.7	2	8.3					24	100	22	91.7	NC
50	A family should not spend a lot of money on a baby's funeral.	F	5	20.8	12	50	5	20.8	2	8.3	17	70.8	10	41.7	-7
51	A husband and wife have a right to grieve a miscarriage.	T	24	100							24	100	24	100	NC
52	Suicide is an unpardonable sin, and I should inform them of this when a loved one has committed suicide.	F	21	87.5			3	12.5			21	87.5	24	100	3
53	When a loved one is terminally ill, the family should try not to grieve until they actually die.	F	21	87.5			2	8.3	1	4.2	21	87.5	23	95.8	NC
55	How I grieve is the right way to grieve.	T	4	16.7	7	29.2	9	37.5	4	16.7	11	45.8	13	54.2	NC
56	It's okay for a woman to get emotional when a loved one dies, but a man should be strong at any cost.	F	23	95.8			1	4.2			23	55.8	24	100	NC
57	When a bad person dies, their family should grieve.	T	15	62.5	2	8.3	7	29.2			17	70.8	22	91.7	5
58	Good people should live longer than bad people.	F	19	79.2			3	12.5	2	8.3	19	79.2	22	91.7	3

		1	2		3		4		5		6		7		8
#	VALUE QUESTIONS	Consensus Ideal Response	Pre Ideal Post Ideal		Pre Ideal Post Not Ideal		Pre Not Ideal Post Ideal		Pre Not Ideal Post Not Ideal		Pre Test Ideal TOTAL		Post Test Ideal TOTAL		Change Post-test minus Pre-test TOTALS
			#	%	#	%	#	%	#	%	#	%	#	%	#
59	Poor families should not spend a lot of money on funerals.	F	2	8.3	6	25	14	58.3	2	8.3	8	33.3	16	66.7	13
61	After the death of a loved one, their name should not be mentioned in jest.	F	17	70.8			4	16.7	3	12.5	17	70.8	21	87.5	4

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